

REVIEW

College of Medicine, University of Saskatchewan

Commissioned by Saskatchewan Health

BLUEPRINT FOR CHANGE

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1.0 REPORT OVERVIEW

1.1 Executive Summary

Blueprint for Change, commissioned by Saskatchewan Health, is intended to be an analysis of structural and process issues within and associated with the College of Medicine, University of Saskatchewan.

As inputs to our thinking, we have reviewed a substantial literature base, held approximately 80 interviews, conducted a province-wide physician survey, and undertook a detailed investigation and analysis of financial information and operating funds. Throughout our work, we have had unrelenting assistance and overwhelming responsiveness, and it has been apparent that there is a strong undercurrent of wide-ranging, meaningful support for a sustainable College of Medicine. Notwithstanding such support, we have elucidated many issues and opportunities for further consideration and improvements, associated with broad areas of governance, management, funding and accountability. Accordingly, we have structured our recommendations to take these factors into account and have organized our recommendations to include these categories, in addition to manpower, physician resources and support.

The recommendations in this report are wide-ranging, yet sequential. They call for action now, but in a thoughtful and orderly way. In our view, it is critical to move to the first steps of implementing this Report, which include necessary structural changes in the management of the Dean's office, as well as the creation of a sub-Board for Health Sciences, University of Saskatchewan. Over the longer run, we encourage the University and Province to seriously consider the creation of an executive position of Vice-President Health Sciences and, subsequently, to consider merging the Health Sciences. The **Blueprint for Change** will require further formative work and analyses for certain directions.

Funding of the College of Medicine needs serious reconsideration, particularly in light of compensation adjustments that have recently been enacted. We propose that the College of Medicine receive an additional \$2.909 million for 1999/00 fiscal year. Additionally, for the fiscal year ending April 30, 1999, we have recommended that the projected deficit of \$910,000 in the Clinical Services Fund be eliminated on a one-time basis, by contributions from Saskatchewan Health (\$533,705) and UofS (\$376,295).

In making our recommendations, we are aware that there is an urgent requirement to establish an equitable solution for faculty compensation, which should arise from the establishment of a defensible compensation policy. We suggest that before new funding for faculty compensation flows, however, that a commitment be made by the College of Medicine to undertake this comprehensive compensation review and potentially re-open previous salary agreements. Furthermore, we are suggesting that there needs to be a national compensation survey which would further help to ensure external equity in payment systems for the faculty of the College of Medicine.

Of particular note in our Review and analysis, has been the irrefutable reality that there is a malalignment of goals and objectives between the College of Medicine and Saskatoon Health District. We have suggested that there should be a fusion of the Vision and Mission of these entities and several structural changes which will consolidate the interests and eliminate the

"two solitudes," which have been permitted to historically co-exist and compete.

Beyond Saskatoon, it is necessary for the College of Medicine to reconcile its roles and expectations in Regina. The College Of Medicine must have a realistic, value-added presence within the Regina Health District. This can be accomplished not only without compromise but, in fact, with resulting greater strength for having clarified this.

A matter of continuing concern in the Province is the issue of physician recruitment and retention. These and other expectations are embodied in what is commonly referred to as the social contract between the College of Medicine and the Province and its people. A greater level of understanding needs to be accomplished with respect to this social contract, such that the College of Medicine can more clearly work towards targets which are meant to relate to social responsibilities and, accordingly, can be used to assess performance. We have recommended a number of items to increase physician recruitment and retention and a meaningful involvement of the College of Medicine in the provincial medical manpower planning process.

To actualize this **Blueprint for Change**, will require the collective will of many and their commitment that the College of Medicine will be strengthened and rendered sustainable. A problem-solving and compromising environment will be necessary to achieve this. The chain of events should commence with an urgent requirement for the College of Medicine and its key stakeholders to enunciate core values and develop the Vision and Mission. In our estimation, the willingness and the ability to do this is now only matched by the sense of necessity of having to do so.

In the end, our view is the College of Medicine is not only able to be improved, but in fact it must be. The College of Medicine must develop the capacity and resilience to deal with perpetual change in health and the health care delivery system. There is no question that the collective will shall be tested.

We respectfully submit that the College of Medicine is an enormous attribute to the Province of Saskatchewan and its people, their health and health care. Every effort should be made to nurture it to the point of organizational health and wellness that it deserves.

1.2 Report in Context : A Blueprint for Change

It is a common practice in reading reports of this size and scope to review the Executive Summary and Recommendations and believe that clear and substantive understanding can be achieved. We have written our Executive Summary so as to capture the spirit of our Report, but it cannot capture its contents. The Recommendations focus our thinking and analyses. What connects these, of course, is the body of the Report derived from what we have heard, seen, and received as inputs on governance, management, funding and accountability.

We encourage readers to review the entire Report in order to fully capture the breadth of this work. Beyond this, we encourage a concerted, thoughtful approach to receiving and reviewing this Report, using it as a **Blueprint for Change**, to fashion the nature and timing of implementation required to make a difference.

This Report is meant to strengthen the College Of Medicine (COM). To do so it has to be taken seriously and with the collective will that it be used as an instrument for change. This is not to say that all of the recommendations should, or are able, to be implemented at this time. Some call for further work and thorough evaluation, not reasonably possible within the context and time-frame of this Review. Accordingly, we ask readers to receive this **Blueprint For Change**, which together with the thoughtful and collective will of key stakeholders can be used to achieve the intended purpose assumed in this Review, namely:

The Province and the public of Saskatchewan wish to maintain a strong College of Medicine, directed at serving the needs of the Province, in terms of optimizing the health and health care of citizens.

2.0 RELEVANT BACKGROUND AND RATIONALE OF REVIEW

2.1 Relevant Background

From 1829 to 1967, Canada established 16 medical schools, all of which remain operational. Canada's medical schools are responsible for both undergraduate and postgraduate medical education, which is now focused in universities. This has been the case since the early 1970's.

Although medical education and research has been central to the mission of universities, the locus of educational activities has shifted to academic medical centres and, in recent years, to the community. This leaves academic medical centres striving to become academic health centres. Concurrently, undergraduate and postgraduate trainees have moved to accommodate the ambulatory shift, this has impacted traditional relations and service commitments of faculty and trainees alike.

Canada's medical schools receive accreditation for undergraduate medical education through the Committee for the Accreditation of Canadian Medical Schools at the Association of Canadian Medical Colleges (ACMC). Additionally, accreditation of U.S. (and Canadian) medical schools is accorded through the Liaison Committee on Medical Education (LCME) for the Association of American Medical Colleges (AAMC). All Canadian medical schools are currently accredited and are required to be so. Accreditation for postgraduate training is conferred by the Royal College of Physicians and Surgeons of Canada (RCPSC) for specialty training programs, and the Canadian College of Family Physicians (CCFP) for family medicine programs. Accreditation by both Colleges is a requirement for postgraduate medical education programs.

Each of Canada's 16 medical schools establishes a Mission Statement and has its own Vision for medical education and research, parallel and consistent with the universities in which they are located. While there are distinct comparabilities and substantial consistencies in medical education from the perspective of structure, process and outcomes, there are also notable differences across the medical schools, making each specific and unique. Arguably, this is the way it should be!

Current day challenges facing the Canadian medical schools are many and varied, but have been profoundly accentuated by fiscal restraint in both post-secondary education and health, most notably influenced by public expenditure reductions through the early and mid-90's. Coincident with this, the health service delivery system has gone through remarkable and dramatic change, in some cases matched by unprecedented expenditure and budget reductions.

In all, 9 of 10 provinces have adopted altered forms of governance and management, largely in the direction of regionalized or district boards. Management infrastructures have assumed responsibility for the full care continuum, as well as the broader public and population health agendas. For better or worse, we have come a long way from a Dean of Medicine popping into the respective university hospital president's office, and both sorting things out in a direct and personal way.

Unfortunately, many changes have taken place in Canada with little or no regard to the impact of health care restructuring on medical schools. Similarly, the faculties have not anticipated,

prepared for, or necessarily accepted and adapted to these changes. Not surprisingly, new complexities and problems have followed this quantum of change, largely stemming from poor alignment of the goals, objectives and strategies of university-based medical faculties and the health services delivery system.

In the post-war years of Canada, incremental and steady increase in the complexity and role of the acute care delivery system led to the Canadian version of what has often been referred to as the Academic Medical-Industrial Complex (AMIC), which we discuss in some detail in 8.0. For the most part, each medical school has a large university-based teaching hospital which houses most of the academic faculty and resources and a great deal of the tertiary care delivery for each Province. Academic medical centres provide a wide spectrum of clinical services to regional, provincial and, at times, national populations, while at the same time educating future health care professionals and conducting biomedical and clinically relevant research and scholarship. It is apparent, however, from experience in the United States, that the AMIC has had to weather difficult times in the current age of value-for-money, in which solid business operations and astute attention to efficiency and productivity have been sacred touchstones.

Closer to home, and within the context of health care restructuring in Canada, medical schools and academic health centres have been forced to take on larger roles in managing and participating in health services delivery. This has raised fundamental questions about the roles and responsibilities of medical schools and their faculty, particularly within the context of broader social responsibilities believed to be associated with professional schools of this type.

2.2 Glimpse of History

Medical education began in Western Canada in 1883, with the opening of the Manitoba Medical College.¹ Medical instruction in the pre-clinical years began in Edmonton at the University of Alberta in 1913, with later extension in 1925 to a complete degree program. The University of Saskatchewan (UofS) was founded in 1907, and its early plans included the development of a College of Medicine (COM). The first President, W.C. Murray, entered into agreement on behalf of the UofS with the City of Saskatoon to build a teaching hospital in 1911. An agreement was reached to lease a parcel of 8 acres of land adjacent to the campus. However, controversy developed when some citizens felt that the existing City Hospital, constructed in 1909 on the west side of the river opposite the University, should be designated the University Hospital rather than constructing a new facility near the University. It is a matter of opinion as to the extent that these historical roots bred further controversy which may have present day derivatives.

Arguably, another current-day controversy may well have taken its origin from about the same time, when a law school was being established in Regina. Contemporaneously, there were significant discussions in regards to the Regina College developing a medical school. The Plains Hospital was to be the University Hospital. Not to recount the history and politics of these historical roots, Regina's medical school was never established, which is not to say that the presumed need or support for it disappeared.

The School of Medical Sciences at the UofS was first established as a two-year, pre-clinical program in 1926. As is often told, anatomy and physiology was first taught in the University's

greenhouses. However, the formal completion of the COM at the UofS takes its origins much later, around 1939, when Manitoba mandated that students of Saskatchewan would no longer be freely accepted for transfer and training. In the spring of 1945, the Legislature voted \$100,000 to begin construction of a medical building on the university campus. The cornerstone of the medical building was laid in August 1946. It later opened in May 1950. Planning for University Hospital began in 1943 and it was finally constructed in the early 50's. Presiding at the opening ceremonies of the University Hospital, on May 14, 1955, was Premier T.C. Douglas.

2.3 Rationale of Review

This review is neither directed to nor capable of reviewing countless historical events, circumstances, accomplishments, issues, achievements or failings from earlier times. To a varying degree, depending on the interviewee or correspondent, the historical origins and roots of the COM track like veritable strands to the present, and for some offer differing levels of explanation, if not understanding, of perhaps more systemic issues, some of which ultimately have led to the request for this Review. Of course, a complete understanding of the rationale for this Review is best understood by those asking for it. In a sincere attempt to fully understand this rationale, the reviewers are confident that the intent behind this Review is to strengthen and stabilize the COM, for a strong, productive future. It is this overriding intent that has called into question a number of issues associated with governance, management, funding and accountability. Additionally, questions have been raised about many operational issues associated with the COM and, furthermore, its social contract with the Province of Saskatchewan.

This is not the first time that the COM has been reviewed. While not being unduly influenced by the previous Kerr White Report of 1989, we did take these materials into account. For a variety of reasons, many of the recommendations in the Kerr White Report were not implemented. While some recommendations, with adaptation, have present-day currency, many do not or are not the focus of this Review.

Commenting further on the rationale behind this Review, it is fair and appropriate to suggest that several problems appear to have precipitated this undertaking. This has focused a desire to squarely face the issues, as a means of strengthening and sustaining the COM. These precipitating events include such examples as the resident strike of 1995 and the recent reimbursement issues in the COM, precipitated by compensation adjustments made to neurosurgery, and other surgical specialties. These and other events have cast a spotlight upon the COM. We have undertaken and reported this work, mindful of historic context and rationale for the Review, and in alignment with the Terms of Reference (Appendix 5).

The major assumptions associated with this Review are offered in Section 3 of this report. Clarification of terms and abbreviations, and methodology is detailed in Sections 4 and 5, respectively. Section 6 represents the problematique, patterned after the Terms of Reference, as is Section 7 on analysis and solutions. Section 8 offers a view of the Academic Medical-Industrial Complex, setting the stage for Section 9 and discussion of several overarching and specific issues. Section 10 proposes an innovative **Blueprint for Change** for the Health Sciences at the University of Saskatchewan, while Section 11 offers suggestions as to how and when to proceed. Section 12 suggests that there be put in place a systematic evaluation and

follow-up procedure subsequent to this Review.

It is important for the readers of this Review to recognize that it was the reviewers' intent to elucidate the structural and process issues within and associated with the COM. By better understanding them, and their associated origins and problems, we felt that we would be better positioned to tender thoughtful recommendations able to be implemented, and which would be seen to be practical and useful. Accordingly, if the tenor of this Review appears to be unduly weighted towards criticism of the COM, and appears not to be sufficiently balanced by commendations and recognition of the untold valuable and countless accomplishments of the COM, no harm is intended by this. Most notably, we have not approached or requested this work with any intent of attributing fault or culpability for actions or faults, real or perceived.

We recognize that the COM as an institutional structure of medical education and research has withstood the test of time and can be justifiably proud of its accomplishments. Its graduates have unquestionably contributed to the health of Saskatchewan's people. The COM has taken up its position as one of Canada's 16 successful medical schools.

We respectfully request that the reader accommodate our failure to necessarily recognize and commend the COM. Rather, we have concentrated on elucidating problems and on providing constructive feedback that can be assimilated and used to the best advantage of the future COM.

3.0 VALUES AND MAJOR ASSUMPTIONS

3.1 Values

Decision-makers operating in a social context must do so in a way that reflects their underlying values system. Although everyone who is required to render a decision must do so under conditions in which their beliefs, needs, interests, and preferences impact the variety of choices which are to be considered, few are bold enough to identify the underlying values which guide their decision-making.

Approaching the challenge of identifying an ideal future for the COM requires one to be more circumspect and explicit about one's values, beliefs, and assumptions that condition the decision-making process. The explicit identification of values and decision-making criteria serve as a base-line statement for what decision-makers consider of paramount importance. Not only do identified criteria serve as beacons to be navigated when varied courses of action present themselves, but they also represent potential constraints in the choice of appropriate solutions.

It is for these reasons that we have attempted to be explicit about the values which have guided us in this Review. We are mindful that the present and future role of the COM will naturally incorporate the goals, preferences and interests of a variety of stakeholders, some of which will undoubtedly seek to secure incompatible ends. Nevertheless, we are guided in our deliberations by six fundamental principles. We believe that any existing or future role, structure, or function of the COM must be inculcated with the following six principles:

Ensure accountability: The primary mission of the COM should be to enhance the health and welfare of the people of Saskatchewan. The COM should be morally and financially accountable to the citizens of the Province, such that the College will pursue a teaching, research and service mission that is relevant, meaningful, and consistent with the goal of continuously and relentlessly improving the health status of the population.

Enhance equity: The COM should attempt to create the means and mechanisms by which its activities and actions are seen to be equitable, fair, and just, by relevant stakeholders. Decision-making procedures should seek to promote a sense of fairness and due process among those who have a stake in the outcomes of those decisions. These procedures and processes should be made as transparent as possible. Mechanisms that facilitate the attainment of procedural equity (fairness in process) and distributive equity (fairness in outcomes) should be pursued and established.

Increase participation: The COM as a social organization should attempt to foster a culture that encourages, values, and seeks the input, participation, and collaboration of its key internal and external stakeholders. The COM should pursue its mission by creating for relevant stakeholders mechanisms and forums for enhancing and augmenting democratic participation in its affairs.

Promote acceptance: The COM should attempt to lower the tenor of discourse and conflict by creating mechanisms that promote social harmony and acceptance.. By enhancing equity and increasing participation in decision-making by relevant stakeholders, there is a greater potential for acceptability for any course of action which is contemplated.

Improve Responsiveness: The COM does not operate as a closed system. Rather, the College must be responsive to constant or sudden changes in its external environment so as to better enable it to adapt itself to new contingencies, contexts, and challenges. The COM should create the means and mechanisms by which it can improve its internal capability to respond to new external environmental opportunities and threats. The COM must create the means by which it is able to increase the speed of responding to its environment.

Empower stakeholders: The COM should seek to empower its relevant stakeholders, both internal and external. This requires that the College enter into partnerships with these stakeholders, by widely sharing information, resources, and power.

3.2 Major Assumptions

The Province and the public of Saskatchewan wish to maintain a strong COM, directed at serving the needs of the Province, in terms of optimizing the health and health care of its citizens.

The COM contributes to the health and health care of its citizens through its joint commitments to teaching and research, and carries the added responsibility of clinical service delivery.

Service delivery contributions by the COM, faculty and staff are inextricably linked to teaching and research, and there is a further inextricable linkage of the COM with provision of tertiary services for the Province.

4.0 CLARIFICATION OF TERMS AND ABBREVIATIONS

4.1 Clarification of Terms

Academic Head:	University department's most senior faculty member serving as the Chair of the Department.
Accountability:	Refers to the "liability" of action. Those who are accountable are liable for the results of their actions or omissions.
Authority:	Refers to the "right of action." Those who have authority have the right to perform. This right is inferred through "rational-legal" means, through traditional (ie. hereditary) means, or through referent (ie. charismatic) means.
Clinical Head:	Saskatoon Health District's appointed clinical chief of a particular clinical service in the District.
Full-Time Without-Term Faculty:	Means that the faculty member's standing is as defined by separate agreement. Under these agreements, there is an initial probationary period, after which "without-term" appointments are of an indefinite duration and terminable on 90 days notice by either party at any time. The agreement specifies the distribution of time between academic and clinical services, and research.
Governance:	Refers to the articulation and promulgation of organizational values and philosophy, and the making and administration of broad policies for the effective operation of an organization or system of organizations. It reflects a sovereign authority in the exercise of its regulatory power and provides legitimacy toward the management of the enterprise.
Management:	Refers to the act, manner or practice of achieving organizational objectives through the work of others. Its primary functions include planning, directing, leading, staffing, and controlling the operations of the enterprise.
Responsibility:	Refers to the "requirement for action." Those who are responsible are required to perform.
Social Contract:	An exchange of undertakings, or promises, by which each contractor acquires an obligation to act in a particular way, and a right that fellow contractors also act in a particular way. These rights and obligations are conditional- the right of each contractor is conditional on fulfilling obligations.

4.2 Clarification of Abbreviations

2IC	-	Second-in-charge
AAMC	-	Association of American Medical Colleges
ACMC	-	Association of Canadian Medical Colleges
AMIC	-	Academic Medical-Industrial Complex
CCFP	-	Canadian College of Family Physicians
COM	-	College of Medicine
CME	-	Continuing Medical Education
CPP	-	Clinical Practice Plan
CPSS	-	College of Physicians and Surgeons of Saskatchewan
CSF	-	Clinical Service Fund
CTU	-	Clinical Teaching Unit
HSURC	-	Health Services Utilization and Research Commission
JURSI	-	Junior rotating student intern - fourth year medical student trainee (Pre-MD)
LCME	-	Liaison Committee on Medical Education
PAIRS	-	Professional Association of Interns and Residents of Saskatchewan
PGME	-	Postgraduate Medical Education
PGY1	-	First postgraduate medical education year (Post-MD)
RCPSC	-	Royal College of Physicians and Surgeons of Canada
SAHO	-	Saskatchewan Association of Health Organizations
SHIN	-	Saskatchewan Health Information Network
SMA	-	Saskatchewan Medical Association
UGME	-	Undergraduate Medical Education
UofS	-	University of Saskatchewan

5.0 METHODOLOGY

5.1 Semi-structured Interviews

The central input to the Review was accomplished through approximately 80 semi-structured interviews over the period of July to September, 1998 (Appendix 4). Most interviews were held on a one-on-one basis, with occasional small group meetings. While interview content was not standardized, there was general consistency to the structure and content of most interviews, taking into account the organizational focus or perspective that would be anticipated from interviewees and correspondents of any specific orientation.

Most interviews were of 60-90 minutes duration and dealt with selective matters pertaining to the Terms of Reference, or related issues. The interviewees which were included were meant to represent the range of opinions and perspectives on the issues raised in the Terms of Reference. Input from these sources was not randomly selected, and was not the subject of scientific sampling. This purposive sample attempted to be inclusive of all those who requested such participation or were suggested by either Saskatchewan Health, COM and its faculty, or representatives of Health Districts and clinical practice. No direct request for participation was denied.

Qualitative input from interviews was informally analyzed for repetitive themes and consistent messages and perspectives. In later selected interviews, content believed to be representative or widely held was re-examined in an attempt to ensure reliability and appropriate interpretation of former contents. In addition, a third-party, anonymous, independent reader, well-known and respected in the Province of Saskatchewan, reviewed the edited field notes from representative interviews. This was done in an effort to provide missing information, to clarify misinterpretation or data, and suggest further consideration or review.

5.2 Province-Wide Physician Attitude Study: Methods

In order to complement the qualitative data drawn from individuals, interviews, and correspondents, in conjunction with SMA, we sought perspectives of Saskatchewan's physicians.

In late September 1998, 1549 Saskatchewan physicians were surveyed to learn of their attitudes, opinions, and beliefs concerning the role, function, management, external relations, and performance of the COM. The survey instrument used to collect data from Saskatchewan physicians covered a wide variety of issues. Four categories of information were constructed with respect to physician attitudes toward the COM: role and function, management and leadership, relationship with stakeholders, and quality of education programs.

The mailing list used to access physicians was acquired from the SMA, which lent their assistance as co-sponsors.

All physicians were informed that their participation in the study was voluntary and that their individual responses would remain anonymous and confidential. A single-wave mail survey procedure was used, with no follow-up mail-out. The approach was necessitated by the constrained time frame for the Review.

5.3 Financial Analyses

Methods and analyses with financial and funding considerations are elaborated in 7.4.1. Construction and review of statements of operation and fund balances are presented and explained for the seven funds of the COM.

5.4 Liaison Committee on Medical Education Comparisons

Comparisons with other medical schools is detailed in 7.5.3 and is limited by available and current benchmark data. Accordingly, comprehensive analysis was not possible.

6.0 PROBLEMATIQUE AND DIAGNOSTICS

6.1 Accountability

6.1.1 Governance

To examine the governance for the COM, it is necessary to examine the relationship with the University, its Board of Governors, and Executive. Correspondingly, if one is to elucidate the problems and issues challenging the management of the COM, it is particularly important to examine and discuss the relationships with Saskatoon, Regina and other Health Districts, and the physician community, to name but a few. From both the perspectives of governance and management, it is necessary to examine the relationship of the COM to Saskatchewan Health.

In each of these circumstances, there was overwhelmingly repetitive and consistent input from the semi-structured interviews to highlight several problems and issues diagnostic of structural or process-oriented elements requiring attention, further analysis, suggestions and recommendations. The semi-structured interviews were supplemented by the province-wide Physician Attitude Survey. In most circumstances, there was common agreement around several issues associated with the governance and management of the COM.

It is a widely-held view that substantial distance and a gap exists between the Board of Governors of the University and Dean's office of the COM. Correspondingly, this gap is believed to exist between the Corporate Executive of the University and the Dean's office. In reality, information exchange in both directions is limited. Reporting is selective and all too frequently comes in a just-in-time fashion, or once a problem has reached a point of public visibility or substantial concern. While on the one hand the COM feels a lack of support and leadership from the University, the University sees the COM of Medicine as, in some way, separate and unnecessarily distinct onto itself, and to a certain extent not fully accountable for its actions.

Regardless of how one sees the real or imagined relationship of the COM and the University's Executive and Board, it is fair to say that it is not currently harmonious or designed for success; in this case, success being a sustainable and strong future for the COM, and a sense of accomplishment and pride in the COM by UofS, as one of its finest academic constituents.

Health Sciences governance and management is, of course, an issue at all Canadian universities. Within the Health Sciences there are multiple professional schools and faculties, with differing power bases and constituencies, internal and external to the University. As well, the professional and Health Sciences colleges carry additional responsibilities for, what is referred to as, the social contract with the Province and its public. This is usually manifested through commitments to delivery of services and programs. Accordingly, the fit of a medical school within a university is, by its nature, somewhat incongruent, which is not to say that it is unmanageable or ungovernable, rather, there is a strong argument to have very specific approaches to and measures for governance and management.

6.1.2 Management and Operations

It is often said that hospitals are among the most complex of organizations to manage. This is particularly the case for academic medical centres. Correspondingly, medical schools with their inextricable responsibilities to service delivery, as well as teaching and research, are particularly complex and require flexible management styles that take into account diversity and pluralism of perspectives, the need for a consensus-building collaborative style, and fastidious attention to transparency and accountability to many stakeholders, both internal and external. For the COM, this is compounded by exigencies associated with physician resources, and a highly variable understanding of the presumed social contract that the COM has with the Province and its people.

The impact of restructuring and integrated delivery systems in relation to the COM, and indeed all faculties of medicine in Canada, has not been properly studied and it will perhaps take some time to be fully elucidated. Empiric evidence aside, the degree and scope of change in service delivery in this past five years has been unprecedented. There is every reason to believe that this has had major impact on the COM's ability to achieve its mission in teaching and research. In fact, this has challenged its core understandings of and commitments to service delivery.

Change has impacted and tested the mechanisms and relationships that align the goals and objectives of the COM to those of the Health Districts in Saskatoon, Regina, and elsewhere in the Province. In fact, it is widely recognized that there has been a fundamental fracturing of roles and relationships between the COM and the service delivery system. Furthermore, not all of the mechanisms are in place to ensure that strategic alignment is reestablished and successfully achieved.

The Dean's Executive management structure is particularly non-hierarchical, and while the organizational chart reflects what appears to be a large staff, key positions such as the Associate and Assistant Deans are part-time. Furthermore, there is no individual with the direct role and responsibility for managing clinical services and relationships with Saskatoon, Regina and other Health Districts. This has compounded misunderstandings associated with service delivery and the COM, and has frustrated Service and Academic Heads alike, all trying to achieve their objectives, regrettably in what often appears to be in a competitive fashion or at cross-purposes.

Having part-time postgraduate and undergraduate Deans, together with their busy, additional clinical responsibilities, limits their effectiveness and necessarily their degree of commitment. Furthermore, the part-time nature of the Assistant Dean, Research has meant that there has

been less attention to key issues than there otherwise would be, if there were a full-time incumbent. There has been insufficient attention to internal grant reviews and to organizing graduate training programs and supervision. Furthermore, cross-subsidization from the Department of Biochemistry to underwrite the salary requirements of the current incumbent is not a sustainable proposition.

Beyond this, the management structure of the Dean's office which handles a \$71.2M financial portfolio, does not possess sufficient financial infrastructure and reporting processes. Frankly, it has to be realized that the job description of a Dean of a Canadian medical school has changed markedly, as a direct consequence of health system restructuring that has occurred in the 1990's. Correspondingly, the organizational structure that needs to support the Dean's position has to necessarily change. Without this, one is left with a traditional model of, in this case, at least 31 direct reporting relationships, for all aspects of education, research, service delivery, and broader policy issues, all coming to a single doorstep. Upon thoughtful reflection, this is not a recipe for success.

This creates an untenable situation whereby the Dean, as a direct report for many departments requires direct decision-making in a very large number of areas, from the trivial to monumental. Many of the decisions should be made at lower levels in the hierarchy. This creates imponderable pressures on the Dean's time as departments curry favour with the Dean in the hope of getting him to make decisions that support their objectives. It also adds to the conflict and competition among departments as each competes for scarce resources, with the Dean being placed in a situation whereby he wishes such problems would be solved at lower levels, rather than always landing on his desk.

Part of the problem that exacerbates things is that most Deans or CEOs tend to enjoy power and the status that goes along with it. Accordingly, many don't like giving any of it up. It is very common in organizations with very powerful CEOs and much less powerful underlings.

6.1.3 Decision-making and Reporting

Given the issues outlined in the problematique and diagnostics on governance and management, it is not surprising that this has been the cause of, or caused by, several problems associated with decision-making and reporting. There is a widely held view of a lack of comprehensive understanding of the COM from virtually any perspective of governance, management, funding and accountability. This view appears to emanate from an absence of comprehensive reporting and consolidated processes for governance and management across the full spectrum and domains of interest. Notwithstanding this perspective, or its realities, the COM justifiably feels inundated with the frequency of reporting that is required, often in sporadic fashion and with a considerable hassle factor. Information overload has impacted the Dean's office and has begun to characterize the meetings of the Academic Heads, where there is a common perception that they have gone from 'famine to feast' with respect to information and reporting on financial affairs, and the general state of the COM. More than one Academic Head has surmised that this Review has appeared to precipitate an enhanced desire for more organizational and collaborative discussion, despite the fact that this has been encumbered by corresponding suspicion and dissatisfaction associated with recent reimbursement and compensation processes.

Another widely held view regarding decision-making in the COM is that it is too concentrated in too few hands, with the span of control being too concentrated in the single office and person of the Dean. Structurally, this should come as no surprise and has been a long-standing tradition in Canadian, and in fact North American medical schools. However, this speaks to the requirement for a management and reporting style with particular regard and attention to collaborative and shared decision-making, particularly when it relates to central issues of importance to the faculty and academic staff, such as compensation, faculty evaluation, resource allocation, and so forth.

While it is widely-held that the current management style of the COM reflects a "benevolent dictatorship," other perspectives are far more or less complimentary and represent a full spectrum of views. Without necessarily attaching greater or lesser weight to any of these, it appears clear that internal and external communications of the COM are insufficient to deal with the volume and nature of decision-making. Furthermore, the image of the COM and the Dean's office has to be strengthened.

Organizational structures and processes need to be re-oriented towards a problem-solving attitude, which is respectful of the wide array of input from individuals, and where it is quite clear that there are no "inner circles" of decision-makers and there is no preferred status. Processes must be, and must be seen to be fair, transparent, logical and free of reprisal. This is not how the current administration and processes are viewed, notwithstanding the best efforts that may have been directed to administration. The result has been a pervasive and encumbering lack of trust, and substantial dissatisfaction with the apparent loss of fairness, in what was previously seen as internal equity in the COM.

Feelings of internal inequity have developed insidiously but with historical roots clearly developing around the time that practice plans became departmental in 1987. Accordingly, there are many individual fiefdoms and the decision-making process in the COM is not believed to be harmonized. Most certainly, it is not transparent. It is these factors which have questioned both the credibility and integrity of the COM in recent years. These matters have been particularly exemplified by vicissitudes arising from the housestaff strike in 1995, and financial transactions that were widely perceived as "closed door" negotiations, associated with adjustments in faculty compensation.

The central body for decision-making in the COM, beyond Executive Council of the Dean, is of course the Academic Heads, who meet monthly. The ambiance of and satisfaction with these meetings has deteriorated. Over time it has become apparent to most Academic Heads that the process of allocating compensation adjustments to faculty was flawed, was not collaborative, was not seen to be particularly thoughtful, understandable, or defensible and, most definitely, was not considered to be fair. This has resulted in a continuing, worrisome and pervasive distrust and dissatisfaction, particularly amongst those departments and faculty members that have not received additional compensation, and in those who feel that they are excluded from the inner circle of power and influence which is believed to exist.

It is not the prerogative of this Review to judge the degree and attribution of fault associated with processes that have ensued since the now infamous "neurosurgery deal," but the reality is that this action clearly set in motion a cascade of events that has resulted in widespread internal dissatisfaction by Academic Heads and faculty, who are now more inclined than ever to

find reasons for internal dissatisfaction, rivalry and interdepartmental squabbling. The situation continues to be poorly controlled and managed by those responsible. This is best exemplified by several departments recently threatening some form of altered relationship or frank withdrawal from the COM. While some departments appear to have been more patient than others, these are matters of serious risk to the COM and pervade the decision-making and reporting processes internally.

Beyond the internal management of the COM, the lack of comprehensive reporting to Saskatchewan Health and the UofS is apparent but is, nonetheless, both understandable and rectifiable. Additionally, wider communications and reporting to people of Saskatchewan as a means of discharging social responsibility is not well addressed at this time. Effective internal and external communications are critical pieces in rebuilding the image of the COM, as a strong and sustainable force directed towards the improvement of health and health care of the people of Saskatchewan.

6.1.4 Physician Resources: College of Medicine and the Province

The COM is inextricably linked to the provision of tertiary care services and many provincial programs. Accordingly, without a strong COM, certain specialty and tertiary care programs are less likely to flourish. Notwithstanding such reality, an effective COM demands strong organizational management, sound strategic planning, and high-quality delivery of services, all of which depends on effective linkages between the COM, Saskatoon, Regina and other Health Districts, physicians and other service providers, working collaboratively to discharge responsibilities and fulfill the Mission.

The COM is one of many key players central to physician manpower planning and effective solutions to physician recruitment and retention in the Province. In other words, the COM is a critically important yet not mutually exclusive stakeholder.

In consideration of broader physician resource issues, problems with critical mass of specialty physicians in Regina are less apparent in Saskatoon. While several departments and divisions are thin or fragile with respect to faculty resources, each department has made some attempt to understand what is referred to as its Faculty Establishment. There is explicit documentation of faculty resources categorized into tenure-track, tenured, without-term, or part-time faculty assignments. Despite the fact that the Faculty Establishment and the documentation associated with this is particularly advanced in certain departments, it does not appear that the faculty members of the academic departments have had appropriate, iterative opportunities to input to this documentation. Furthermore, there has never been a faculty-wide aggregation and analysis of the Faculty Establishment plans, as the basis for more comprehensive contributions to manpower planning within the COM, and a central contribution to manpower planning for the Province. This is not meant to imply that the COM should be in a direct or solely responsible position for physician manpower planning, recruitment and retention for the Province. But, it must act as a key stakeholder and major participant together with other critically important participants such as the CPSS, SMA, Saskatchewan Association of Health Organization (SAHO), Saskatchewan Health, among others.

The physician resource needs of the COM of course are a complex mixture of requirements emanating from responsibilities for teaching and research, as well as service delivery. There is

malalignment between the interests of Saskatoon Health District and the COM, such that, for example, the Search and Selection Committees for academic positions are defined within the Faculty Association Agreement of the UofS, [Faculty Association Agreement, Section 13.5.1 (1995-8)]. Accordingly, there is no direct and meaningful participation of the Health District(s) in decisions to choose academic faculty. Similarly, there are greater opportunities for input from the COM and academic faculty with respect to the appointment of Service Heads, and other key clinical positions and activities in Saskatoon Health District.

It is a strongly held perspective of the reviewers that the physician resource in Saskatoon can no longer stand separately as two solitudes, physicians that "work for the COM" and those that "work in the District." While it is realistic and entirely appropriate to assume that there will and must always be a variety of relationships between physicians, the COM and Saskatoon Health District, this should not be taken as meaning that separate solitudes are any longer appropriate or tolerable, that is, if a strong COM and service delivery system are to coexist. Bluntly stated, the critical mass and dollars are simply not there to permit this and the interests and health care needs of the people of the Province cannot continue to support this.

The problems arising from two solitudes are clearly exemplified in several departments where there is a dysfunctional or inappropriate relationship between the clinical service and academic components, otherwise labelled as the "town and gown." Disharmony occurs in such mundane respects as sharing call, providing other forms of cross-coverage, meaningful peer and professional interactions, and countless other forms of interdependence aimed at accomplishing joint aims and objectives or what ought to be an interdependent COM and health services delivery system, referred to elsewhere as the Academic Health District.

Within the Faculty Establishment, there is one particularly notable classification of faculty that require much more understanding than currently exists. The categorization **without-term faculty** refers to 94 faculty members that have a wide array of relationships and job descriptions. In certain circumstances, these individuals shoulder exceptionally large service roles, with lesser or particularly limited academic roles. Nonetheless, some of these are seen as being important contributors to the CPPs, representing role models of clinical service provision, particularly useful for undergraduate and postgraduate training. However, it is also argued that some, if not many, of the without-term faculty perform functions comparable to tenure-track and tenured faculty. In fact, some hold PhDs and are focused on research. Despite this, few without-term faculty receive any direct compensation for the academic components of their activities, and most receive reimbursement through CPPs and/or the CSF. This, in essence, represents a manifest cross-subsidization of academic medicine from the health services sector, directly or indirectly, either through physician reimbursement or some other form of support by the regionalized health delivery system. These matters are explored at some length in Section 7.5.5.

Physician manpower planning has been well-studied in Saskatchewan as evidenced by the November 1997 Report of the Medical Council's Working Group on Physician Need: **Establishing and Maintaining Specialty Physician Services in Rural and Urban Saskatchewan.** However, there will need to be continuing and unrelenting attention to medical manpower planning, and further attention to physician recruitment and retention for the Province. A strong COM will be essential to maintaining and attracting high-quality medical practitioners in family medicine and in the tertiary specialties.

In Regina, in particular, there is a strong desire to have an association with undergraduate and postgraduate trainees. The teaching role of the limited full-time and substantial number of part-time faculty in Regina remains a valuable and under-utilized resource for the COM. Similarly, the physician resource pool in Saskatoon has a particularly large and committed array of part-time teachers and like so many other medical schools, these part-timers often perceive that they are under-valued and are under-utilized in relation to their potential for making major contributions to undergraduate and postgraduate education. More often than not, this is an issue of mutual respect and recognition of professional value, as opposed to a requirement for reimbursement and payment of these part-time teachers. However, to its credit and unlike some Canadian universities, part-time teachers are reimbursed in the COM, a reality that must be sustained as part of the value proposition of recognizing part-timers.

No diagnostics of physician resources at the provincial level would be complete without alluding to the issue of the social contract for the COM, exemplified by physician recruitment and retention. Broader considerations of this social responsibility will be discussed in 6.1.8. It remains problematic that there is a poorly understood set of expectations of the COM's responsibility for training, recruiting and retaining physician resources. What is left is a COM that is constantly striving to meet an unattainable or implicit target, which is not a subject of common understanding. This results in repeated criticism that the COM is not fulfilling expectations. At present, some 30% of Saskatchewan's practising physicians have graduated from the COM. However, it is quickly pointed out that these graduates are heavily concentrated in Saskatoon and Regina, with many Health Districts having few or no native Saskatchewan graduates and, at present, with little hope of attaining them. For some Health Districts, there is concern that the nature and content of the COM's training programs have under-equipped graduates for the exigencies of rural practice, and the knowledge and skills inherent in more independent and challenging non-urban practices.

Beyond the physician resource requirements for the COM and in the Province, greater attention needs to be paid to the problems associated with highly advanced tertiary programs, sometimes referred to as quaternary services. These include such entities as specific forms of organ transplantation, highly technical and invasive, or specialized surgical techniques, and limited aspects of high-end diagnostics. While there would be a perceived threat to provincial or organizational identity, if there were certain services available in only one western Canadian centre, this is becoming a requirement for serious deliberation. For instance, how many pediatric cardiac surgery facilities does Western Canada need? What if any highly specialized services should be centered in Saskatchewan, as opposed to obtained elsewhere? With countless questions of this sort, the issue is not limited to physician resources or available manpower, but speaks to larger issues of strategic planning for clinical service provision, on a multi-provincial dimension. Nonetheless, considerations of this kind are often provoked by limited clinical resources in the form of physicians, specialized clinical support, highly sophisticated technology, high cost, or the requirement for concentrating clinical expertise in as few practitioners as reasonably possible, in order to perfect quality of practice and/or interventional techniques. Planning and coordination of high-end clinical services in Western Canada is well beyond the purview of this Review, but needs, nonetheless, ongoing and concentrated, deliberative thought and action.

Recommendation:

We recommend that the College of Medicine develop a comprehensive manpower plan, as a critical component of the provincial manpower plan. This should commence with a thorough reconsideration of the Faculty Establishment to be considered initially within divisions and departments, and subsequently across the entire College. Within the plan, there should be estimates and justification of the numbers of full-time, without-term, and part-time faculty needed to fulfill the goals and objectives of the College Of Medicine in teaching, research and service delivery.

Recommendation:

We recommend that the College of Medicine, together as a key stakeholder with other respective parties, including but not limited to, the Saskatchewan Medical Association, the College of Physicians and Surgeons of Saskatchewan and Saskatchewan Association of Health Organizations and Saskatchewan Health maintain a province-wide medical manpower planning process, using the November 1997 Report, *Establishing & Maintaining Specialty Physician Services in Rural and Urban Saskatchewan*, as a basis for further consideration. The provincial plan must incorporate the renewed Faculty Establishment.

6.1.5 Recruitment Coordinator

In an effort to proactively deal with the physician manpower requirements, recruitment and retention for Saskatchewan, a consultant part-time position has been established for a Recruitment Coordinator. Currently, this is a contractual position with SAHO and Saskatchewan Health. The Recruitment Coordinator does not undertake direct recruitment processes, but rather establishes linkages using a community- development model. As presently operational, the incumbent involves the community and capitalizes on personal connections. This position is widely seen as being important to recruitment and retention. An evaluation process is being undertaken to establish the success of this initiative, the vast majority of which appears to be focussed on recruitment of family physicians. While specialty recruitment has not been an active component of the Coordinator's role, given the limitation of time and resources, the Coordinator is not adverse to involvement in specialty recruitment and believes there is a valuable role that could be played.

In this past year, there was a particularly successful Recruitment Fair attended by 23 Health Districts and approximately 300 students. This should be encouraged on an annual, if not more frequent, basis.

There are several notable problems associated with the Recruitment Coordinator's function. First of all, this is a year-to-year contract, due to expire in March 1999. Clearly, the position should be continued, albeit in light of the evaluation, and with strategic reconsideration of roles, scope and alignment to SMA.

One of the greatest barriers to making progress has been the unavailability to the Coordinator of medical student listings and points of contact. Furthermore, it is not always clear with whom the Coordinator should interact in working with the COM.

Having commented on obstacles, there are many attributes aligned to recruitment, such as the existing bursary funds, and the Rural Physician Establishment Grant managed jointly by Saskatoon Health and the SMA, and administered by Saskatchewan Health. Under the terms and conditions of these grants, in the order of \$18,000 is provided to medical students that make a commitment of at least 18 months to a rural placement. Half of the money is paid up front and half at the completion of the commitment. Such a program requires periodic evaluation for evidence of success.

There are suggestions that the incumbent should reside in Saskatoon and be available full-time for the Recruitment Coordinator's role. Additionally, it is felt by some physicians that the Recruitment Coordinator is not tied clearly enough to the SMA, which plays a critically important role in physician manpower planning. Despite these criticisms, it is the view of the Health Districts and many others, that the position of Recruitment Coordinator is a contribution towards improved provincial manpower planning, physician recruitment and retention. Nonetheless, there are a number of potential areas that should be strengthened or expanded as the contract is re-opened and broadened. Notable amongst these is greater involvement by the Recruitment Coordinator in specialty recruitment.

Whereas most of the Coordinator's role has been associated with primary care, an interesting and anomalous situation seems to have occurred with respect to specialty recruitment. Often, this appears to be orchestrated and finalized by Health Districts, to the exclusion of the COM. There are several notable cases where PGME trainees, nearing completion of their specialty training, have become available and are willing to work in Health Districts. Nonetheless, despite awareness of this, Health Districts have tended to make their own arrangements and, in some cases, have underwritten the cost of specialty education at other universities, even if local candidates become available. This is virtually the opposite situation to family medicine recruitment, which is seemingly advocated by the Health Districts and arguably not facilitated by the COM.

The Recruitment Coordinator should play a major role in specialty as well as primary care recruitment, and the many valuable strategies currently in place to attract family physicians should be more broadly applied to include graduates of specialty training programs from the COM. With the length of the training programs being 4-5 years, planning for the incumbency of some or all of these trainees is a distinct possibility, provided that the Health Districts are prepared to work with the COM and the Recruitment Coordinator to secure candidates. In some instances, Health Districts are apparently prepared to fund PGME training, provided that appropriate programs are available within the COM. It seems only reasonable and appropriate that such alignment and mutual interdependence be created between Health Districts and the COM.

On a final note with respect to recruitment, and as noted by the Recruitment Coordinator, it is critically important that physician-to-physician contact not be forgotten or marginalized and, in fact, propagated as an additional means of enhancing physician recruitment potential. Not infrequently, physicians from comparable backgrounds and specialties interact across the

Province and have an awareness of who may be retiring, relocating or becoming available. Often, this can be the first means of elucidating opportunities or candidates to fulfill them. Beyond this, the relationship of physicians and their interactions may be particularly important in securing final understandings and commitments.

Recommendation:

We recommend continuation of the Recruitment Coordinator's role, with expansion in the time commitment and the scope of duties to include recruitment of postgraduate medical education trainees to specialty positions. In re-shaping the contract with the Recruitment Coordinator, we recommend that the position be more closely aligned to Saskatchewan Medical Association, while maintaining a reporting relationship with Saskatchewan Association of Health Organizations and Saskatchewan Health. The position continuation should take into account the recommendations and input from the recent evaluation, and include inputs derived from suitable consultation and reconsideration of role and scope of the position..

Recommendation:

We recommend that there continue to be, on at least an annual basis, a well-publicized and promoted Recruitment Fair involving, undergraduate medical education, postgraduate medical education trainees and Health Districts

Recommendation:

We recommend that the updated list of medical students and their contact points be made available to the Recruitment Coordinator, as soon as is reasonably possible at the commencement of each academic year, with the understanding that the Recruitment Coordinator accepts responsibility for maintaining the privacy of the medical student contacts, though with the further understanding that the Recruitment Coordinator will use this information in dealing with Health Districts' intention to recruit trainees.

Recommendation:

Building on the success of rural rotations between second- and third-year, we recommend that trainees between first- and second-year of medical school training be offered opportunities for rural rotations, with joint assignments to clinicians and administrative staff, so as to develop a broader understanding of the linkage between clinical and management services, while being exposed to the realities and values of rural practice.

6.1.6 Academic Recruitment and Retention

The quality of a medical school turns in large part on the quality, diversity, and critical mass of its medical staff and their clinical practices. Teaching, undertaking and completing research are additional and special skills of the faculty, which are central to the Mission of a medical school. Notwithstanding, the central importance of teaching and research to the Mission, both are indeed the "means" as opposed to the "ends" of a medical school's Mission. The ends are achieving health in the population served by the medical school and its staff.

Academic recruitment is a critical juncture at which there is an opportunity to enrich faculty depth and/or scope. Recruitment to every position in the Faculty Establishment has to be seen as strategic, not only to the internal needs and interests of the COM, but to the larger provincial medical manpower plan. Accordingly, if the COM and the Districts, the SMA and the CPSS are not working from the same medical manpower plan or are doing so in piecemeal fashion, there are inescapable conflicts, overlaps, gaps, and missed opportunities.

The COM has to be a key team player in physician manpower planning in the Province. While not exclusively responsible for physician recruitment and retention, the COM has to be, nonetheless, seen as a critically important stakeholder. As a widely held view, the COM is not well positioned to meet current resource needs in a predictable and organized manner. This is attributable at least in part to the fact that there is not a sufficiently coordinated provincial approach to physician manpower planning and, further, the assertion that the COM may not be as participatory as it could be.

Without doubt, the choice of faculty members is of central importance to a division or department that seeks to acquire additional talent. However, the inextricable relationship between teaching, research and clinical service finds that most academic faculty are meaningfully engaged in clinical practice, some in leadership roles. This mandates that the academic faculty be sensitive and responsive to the goals and objectives of the service delivery system as, indeed, they ought to be to the goals and objectives of scholarly pursuit. This balance is of particular note with respect to those in leadership roles. We have argued elsewhere that roles and incumbents of academic and service positions must operate in concert. Arguably, these functions should be integrated.

Recruitment of academic faculty, and particularly their leadership, must recognize the meaningful responsibilities that these physicians have in the Saskatoon Health District and other parts of the delivery system. It only makes sense, therefore, that there be formal participation in the decisions and choices for these positions. This is currently not the case. Saskatoon Health District does not have a meaningful and appropriate input to the selection of critically important physician resources, despite the fact that they will directly and manifestly influence service provision. This is indefensible and could, and should, be corrected. However, there are substantial obstacles to this. Unlike many other universities, it appears as if the Faculty Association Agreement defines participation in the search and selection processes. Accordingly, such processes are comprised of university full-time faculty. While it cannot be doubted that the majority of input should come from this source, it does not appear logical that this be the sole or exclusive source of input, for the arguments we have raised. Discussion of this matter with university representatives leave the reviewers with concern that this may be quite difficult to change. But, again we believe it should be faced squarely with a thoughtful

approach being given to the impact and implications that the Faculty Agreement have on such matters as effective and appropriate academic recruitment and retention.

While it is true that sub-committees have been established to provide advisory input to the search and selection committees, this does not provide sufficient or effective input from critically important stakeholders, such as the Saskatoon Health District. Regrettably, from the outset, such an approach to search and selection entrenches fundamental malalignments of clinical practice, teaching and research. In the end, it potentiates the two solitudes.

Retention of academic faculty and staff is a serious issue for the COM and offers a consistent challenge to be overcome, particularly once notability and national and international reputations are established by local faculty. This acts as a continuing threat to critical mass, and yet critical mass is part of the solution to preventing the loss of faculty in the first place, particularly the most accomplished. Physician retention, within and related to the COM, has become particularly notable of late and is undoubtedly related to, if not caused by, deteriorating morale, general dissatisfaction with the health care system, the COM, and perhaps clinical practice itself. These matters are elucidated in the physician survey. High dependence on key individuals has placed the COM and, indeed, the service delivery system at greater risk should these individuals choose to change or reduce practice, or indeed to relocate. Regrettably, this has deteriorated to a pervasive culture of coercion whereby individual physicians, groups, or specialties not infrequently threaten withdrawal of service, if the conditions that they seek are not met. In short, "give me what I want, or I will leave." Regrettably, some have gotten what they have demanded and remain unhappy. Not surprisingly, this has neither quelled their desire to leave, nor in some cases has it stopped their departures. This is particularly compromising and disconcerting for the Dean, as well as the Saskatoon Health District.

On the other hand, in defense of those who claim that they have no other recourse than to threaten withdrawal or relocation, this clearly casts a spotlight on processes and mechanisms that are in place to resolve conflict and to clarify agreements and understandings in a fair and open fashion. Some have complained that their concerns are simply not heard or ignored, or worse still that adverse positions are seen to compromise camaraderie or lead to reprisal.

The work climate and decision-making in the COM is not considered to be even-handed to the departments and other groups with need, but rather is one believed to be influenced by non-transparent processes, rife with insider influence, secretive side deals, and inequitable. To the extent that this is true, it has propagated a number of "end runs" which have caused deep divisiveness, particularly when groups directly access Saskatchewan Health and are seen to achieve their objectives, exclusive of the COM. Alternatively, it appears as if it may be easier for a faculty member, department or division to achieve its objectives by in some way aligning with Saskatoon Health District, to the exclusion of the COM. Once again, this propagates the two solitudes, with the regrettable and pervasive view of resource issues, that if you cannot get what you need and want in the COM, it is better to "go to the District" where with "their help" resources can be more easily accessed through Saskatchewan Health. Whether this is true or not, is perhaps less relevant than the overwhelming impression that it is. Accordingly, when an example such as Nuclear Medicine relocating from the COM to Saskatoon Health District comes along, there is tendency for these views to be reinforced. The notion that it is acceptable or better to leave the COM and "go to the District" is so strong and concerning, that several departments at this time appear poised to do so. If this were permitted and occurred, it

would threaten the fundamental viability of the COM.

For its part, we urge the Saskatoon Health District, board and management to avoid supporting these defections and accept the hurdles and challenges associated with partnership with the COM. In so doing, we are reminded of the tremendous advantage and the "jewel in the crown" that comes to a Health District that has within its continuum an interdependent relationship with the COM; not to be controlled or, alternatively to be renegade, but rather to be aligned, nurtured and sustained within the context of mutual benefit and common good to both and, ultimately, the health of Saskatchewan's population.

Recommendation:

Search and Selection processes and committees designed to choose academic faculty and leadership should be reviewed. Currently, there is no direct or sufficiently meaningful participation of the Health Districts in decisions to choose academic faculty. We recommend that the Collective Agreement of the Faculty Association be reviewed in relation to requirement for and implications of Saskatoon Health District's participation in Search and Selection Processes.

6.1.7 Resource Allocation

Allocation of resources within and by the COM is not viewed in a favorable light by most interviewees and correspondents. This was particularly exemplified by the sizable and consistent body of concern associated with recent adjustments in faculty compensation. As a critical element of resource allocation, methods of determining departmental allocations, the amounts, communication processes and in fact the entire decision-making process is viewed as being flawed, and attributable to many stakeholders including the Dean, COM, certain physicians, academic faculty, and Saskatchewan Health. While this is not the only resource allocation issue underlying more systemic problems, it is by far the most salient example that has undermined confidence in resource allocation, and decision-making, and the associated sense of fairness.

Without a COM physician manpower plan, as one component of a comprehensive provincial plan, the Faculty Establishment is largely a subject of individual department's interests or approaches and the Dean's response in the form of support or otherwise. It is not the consequence of a strategic plan for the COM which starts with the Vision and Mission and describes what the COM is to be and how it is to achieve this. In fact, many of the central resource allocation decisions in the COM have a distinct characteristic of being reactive and just-in-time. This is particularly true with respect to how resource allocation decisions are made that impact on the CSF. Described later (Section 7.4.2.2) as a critically important element of financial support and revenue to the COM, the CSF has transformed from being a strategic and flexible revenue source to being a pandoras box of hopes, with wishes and expectations. This is uncomfortably housed within an outdated understanding that is not co-managed between Saskatchewan Health and the COM. The CSF no longer holds the strategic value that it once had. In fact, the CSF has become the major source of cross-subsidization for unfunded academic activity, or other shortfalls, and has a profound and pervasive effect on resource allocation decisions of all sorts.

All too often the resource requirements of the COM are not placed before Saskatchewan Health in a strategic fashion, in congruence with the budget setting and approval process. It is out of alignment with the scheduling of other public programs and government initiatives, as evidenced by the fact that the budget for the fiscal year commencing April 1, 1998 was received in July 1998. The budget should be tabled and approved several months in advance of fiscal year-end, with formulation commencing in the prior year's fall months. Accordingly, resource allocations that move from Saskatchewan Health to the COM appear all too frequently to be reactionary, just-in-time, as opposed to strategic, planned and agreed to in advance, with strategic directions set by the governance body and followed through by the management process in the COM. Problems associated with resource allocation, and decisions pertaining to it, strike at the very heart of the problems in the COM with respect to how it is, or is seen to be, managed.

In a labor-intensive entity such as the COM, the vast majority of expenditures are salary and income. Accordingly, in the face of fiscal restraint or financial reductions, income may be threatened, further impacting the collaboration and cooperation necessary to achieve mutual goals. Fiscal restraint calls more than ever on the requirement of a management process that is open and transparent and which incorporates resource allocation decisions as central to the decision-making process. This must involve Academic Heads and the Dean's Executive. There are widely-held perceptions, however, that resource allocation decisions are concentrated in too few hands or solely in the Dean's, and there are both perceptions and realities that some faculty and Academic Heads have a greater level of influence on resource allocation decisions than do others. To the extent that this is real or perceived, it translates into undermining confidence in the leadership, management and integrity of the Dean's office. Such a situation is not sustainable and, at a minimum, results in internal skepticism, or deteriorates into in-fighting and hyper-competitiveness over resources, as opposed to open and equitable processes for distributing limited resources.

Resource allocation problems of the COM also further underline the dysfunctional relationship and malalignment of goals and objectives with the COM and Saskatoon, Regina and other Health Districts. Decisions made by faculty members or academic heads and the COM, largely located at the Royal University Hospital, have significant impact on service delivery. Correspondingly, decisions made by Saskatoon Health District in terms of service delivery can have a significant affect on the capacity of academic faculty to practice, generate income, or have the necessary resources for teaching and research. Resource allocation decisions, therefore, often result in conflict between the COM and various elements or members of Saskatoon Health District. Many of these become apparent to the Chief of Staff and to the VP-Medicine of the District. Notable examples include in-house coverage for pediatric patients, in light of coverage expectations for pediatric transport and clinical services in Regina; or, decisions with respect to allocation of procedural scheduling and wait lists for MRI. These matters will not resolve without sustained effort and there will be repeated and unrelenting conflict between service delivery and COM, unless attention is paid to alignment of goals and objectives. Joint resource allocation decisions and processes must be in place to accomplish this. As previously stated, two solitudes cannot be sustained in Saskatoon from the point of view of clinical practice, decision-making and reporting, or resource allocation and cost.

6.1.8 *Origins and Understanding of the Social Contract*

The traditional covenant between academic medicine and society has its origin in trust. It was based on the premise that academic medicine's unique programs and commitments were substantial societal contributions, and thus justified generous support and the privilege of self-regulation. This covenant, based on the mutual understanding of both parties, has flourished through the years. Today, the societal trust underlying this long-standing covenant is rapidly giving way to a clarion call for accountability and shared decision-making on many fronts - both in public and private sectors. To adapt to this fundamental change in the nature of the contract between medical schools and the people of this nation, and to respond to their doubts and changing expectations, academic medicine must now redefine and expand its commitments to society.

Social contract theory is a branch of political philosophy. A social contract theory can be defined as one which grounds the legitimacy of political authority, and the obligations of rulers and subjects (and the limits thereof), on a promised contract or contracts relating to these matters. This theory has been revived with a non-traditional end in view- to furnish principles of social justice. Principles of social justice provide a way of assigning rights and duties in the basic institutions of society and they define the appropriate distribution of the benefits and burdens of social cooperation. This revised theory is still a branch of political philosophy, but is more appropriately described as a social contract theory.²

6.1.8.1 *Medical Schools and the Social Contract*

The special status of self-regulation and public support has allowed academic medicine relative freedom to pursue internally generated objectives and goals. Medical schools then are private in structure, but public in purpose, and have an obligation to meet public needs and support societal goals. The relationship between the medical school and society has been variously described as a covenant, a trust, and a social contract, with the latter term accurately used to reflect the obligation of reciprocity between expert institutions and members of society.

McCurdy et al. (1997) provide a justification for the assertion that medical schools enter into a social contract with society.² In the latter part of the sixteenth century, Protestant philosophers sought a democratic principle with which to oppose the authoritarian theory of the divine right of kings. English philosophers John Locke and Thomas Hobbes, and French philosopher Jean Jacques Rousseau developed the concept of a social contract, emphasizing the rights of individuals and the population. In the tradition of the social contract theorists, society gives medical school privileges and resources, and by accepting these benefits, medical schools enter into an implicit contract with the general public, forming the basis for asserting that schools should work for the public good.

The utilitarian tradition also includes the notion of the social contract. From this perspective, society invests in institutions and individuals because it values the return on investment. The special economic and other privileges afforded schools of medicine are the consequence of social value perceptions. Medical school leaders need to understand the valued quality of academic medicine and preserve this quality under changing circumstances.

From a twentieth-century libertarian perspective, health is considered a social good and a necessity, at some minimal level, for full participation in the activities of society. Upholding the

social contract then requires assuming accountability for equitable distribution of a social good throughout society.

Like a legal contract, a social contract involves at least two parties. For each medical school there are a variety of institutions and other entities that are, formally or informally, part of the school's individual social contract. Schools realize benefits from these sources and are accountable to return benefits.

Medical school leaders would benefit from identifying specific stakeholders, beyond the broad category of the "public", and from examining the perceived interests of the stakeholders as related to the school's Mission and well-being. To a varying extent, many medical schools are attempting to do this. Medical schools must develop a process to identify stakeholders and their interests and establish linkages, and must develop a process to establish accountability to stakeholders. Such an approach could serve as a beginning for considering the terms of the social contract, including determining which missions and issues are critical to the social contract and deciding which groups have primary claims on the school's energy and services.

The process of stakeholder identification and the concept of a social contract will increase the school's sensitivity to stakeholders and lead to the realization that a school is dependent on many stakeholders, most of which have not been included in determining the Vision, Mission or future of the school.

6.1.8.2 Medical Education, Research and Service

Medical schools in Canada have a tripartite mission of education, research, and clinical service. Schools must articulate and explicate the public's perceptions and their reciprocal obligations, and must examine assumptions and perspectives regarding institutional stakeholders¹. Concern exists regarding the extent to which undergraduate medical education prepares physicians to respond to the health needs and expectations of society. The biomedical sciences, epidemiology, behavioral sciences, informatics, and medical ethics all compete for space on the priority lists for medical school reform.³ Any reform, now or in the future, must reflect the interest of society in order to fulfill the obligations of the social contract.

The World Federation for Medical Education has recommended that the aim of medical education be to produce doctors who will promote the health of all people and enlarge the range of settings in which educational programs are conducted to include all health resources of the community, not just hospitals alone. Medical education may be moving toward a more community-focused model, and a step closer to fulfilling the social contract and providing education, research and services that address the needs of populations and stakeholders served by medical schools. The establishment, in 1985, of the Network of Community-Oriented Educational Institutions for Health Sciences illustrates a noteworthy example of this movement. This network now has over 250 participating institutional members, and has a primary goal to assist educational institutions that are committed to the training of health personnel whose focus is on the solutions of health problems in the community.

6.1.8.3 Implications of the Social Contract: A Vision for the Contemporary Health System

A social contract model is a useful and appropriate representation of the relationship between

medical schools and society. Medical schools have an obligation to undertake activities that provide external benefits to society in a manner that is responsible, transparent, and accountable. Academic medicine shapes much of what society expects from it and thus must be diligent to avoid the potential conflicts between self-interest and public welfare. Reciprocally, society has an obligation to provide these institutions with the necessary resources to serve the public good. A shared vision for the health system and common objectives and goals is a prerequisite for the fulfillment and sustainability of the social contract between medical schools and society. What does this say for the vision of the contemporary health system? This is best and recently summarized by former Dean, Dr. Eldon Smith.⁴

"The health system is to be patient-focused rather than organized for the convenience of providers. It will be centered in communities and built around their needs. In many jurisdictions, this means regionalism with governance provided by an appointed or elected authority. The new system will focus on wellness rather than illness, so there will be less emphasis on acute-care institutions and their programs. There will be more emphasis on individual responsibility for health. The new system will focus on population health, with the term "health" defined broadly and not merely the absence of disease. The range of services will be determined from an assessment of needs. Only those services shown to be efficacious, effective, and cost-efficient will be made available. Services will be provided in a multi-disciplinary model with multiple points of entry to multiple providers, resulting in a seamless system of care. Finally, the reformed system must be affordable and sustainable".

6.2 Physician Attitude Study

6.2.1 Overview of Study Participants

In total, 610 useable questionnaires were returned, providing an overall response rate of 39.4 percent. Respondents were characterized in a number of ways (Table 1). Forty-three percent of respondents indicated that they were graduates of the COM, and almost 40% percent graduated from a medical school outside of Canada. While just over half of the study respondents hold specialty certifications, two thirds have the LMCC designation. Approximately 93% hold membership in the Canadian Medical Association.

On average, respondents indicated that they have practiced medicine for about nineteen years; thirteen years in their present community. Forty-five percent of respondents practice medicine in Saskatoon, while 25% practise in Regina. Approximately 60% of respondents are engaged in private practice, with 20% in solo private practice. Twenty-nine percent are hospital based, while just under 5% practice in a community health centers. About 15% of respondents indicated that they hold a full-time appointment at the COM, while another 43% hold a part-time appointment. For those with continuing appointments at the COM, approximately 30% receive direct remuneration by the UofS, from academic accounts.

Approximately 65% of survey respondents indicated that they receive all of their earned income through fee-for-service, while another 19% receive all of their income through paid salary. Other physicians in the sample receive their remuneration from a blend of fee-for-service, salary, capitation, or other means of payment.

The physicians in the sample are active, practising clinicians. Over 45% indicate that they practise medicine 60 or more hours per week. Only 15% of survey respondents practise medicine on a part-time basis, that is to say, work less than 40 hours per week.

TABLE 1
Study Descriptives

	Percentage Respondents
Medical Education:	
College of Medicine graduate	43.0
Other Canadian medical graduate	17.8
Other foreign medical graduate	39.2
Medical Certifications/Designations Held:	
LMCC	66.9
CCFP	19.2
Specialty	53.4
Practice Location:	
Saskatoon	45.0
Regina	25.5
Other city	12.8
Town or rural	16.7
Practice Setting:	
Solo private practice	19.6
Group private practice	40.6
Community health centre	4.4
Hospital or other health centre	29.0
Other setting	6.4
Practice Intensity:	
60 or more hours per week	45.4
40 to 59 hours per week	39.4
20 to 39 hours per week	12.3
Less than 20 hours per week	2.9
Memberships:	
Saskatchewan Medical Association	93.7
Canadian Medical Association	93.1
Other Characteristics	
Years from medical school graduation	21.6
Total years practising medicine	18.9
Years practising medicine in present community	13.1

It should be noted that the results of this survey reflect the attitudes, beliefs, and opinions of Saskatchewan physicians toward the COM. Firstly, it is important to condition any interpretation under the caveat that conclusions derived from these findings reflect the attitudes, beliefs, and opinions from a single constituency, albeit an important one. Secondly, it should be stated that perceptual measures of College performance by any third party will have a subjectivity bias that may not be reflected in objective reality. That is to say, belief that something is the way it is, as a matter of opinion, may not actually be true in fact. Nevertheless, perceptions, attitudes, and opinions are important to assess, because people often shape their beliefs or act on their perceptions of reality, even if these perceptions may be false or incomplete.

6.2.2 Physician Attitude Toward the COM: Role and Function

Saskatchewan's physicians were asked to respond to questions concerning the role and function of the COM (Table 2). A majority of the province's physicians believe that the COM is truly committed to improving the health of the people of Saskatchewan. Many believe that the College has a good to excellent overall reputation in the quality of its medical education. More than one-third of respondents believe that it is one of the best medical schools in the country. In fact, almost 60% of physicians affiliated with the COM, indicate that they would be proud of having a son or daughter as a graduate.

Almost 50% of physicians affiliated with the COM believe that it has an appropriate and clearly articulated mission (meaning, of course, that some 50% feel it does not). This sentiment is most strongly articulated by Saskatoon-based affiliated physicians, and most weakly by small city, town, and rural-based affiliated physicians. However, it is unclear from these results whether Saskatchewan's physicians are generally unaware of the basic mandate and Mission of the College, or whether they agree that its existing mandate is appropriate or being achieved. Many physicians practising medicine outside of Saskatoon and Regina may hold a belief that the College needs to be more fully responsive to the needs of rural-based medical practice and the health needs of rural residents.

Almost 47% of respondents indicate that they do not believe the College plays a strong enough leadership role in shaping health policy in the Province. Abrogation of responsibility for influencing the direction of health policy on behalf of Saskatchewan's people represents a missed opportunity. Survey respondents, however, did not indicate what role the COM should play in shaping the direction of health policy or what policies it should seek to influence.

More problematic with respect to the role and function of the COM concerns its reputation for the quality of its medical research. Thirty-six percent of affiliated physicians do not agree that the College has a good reputation for the quality of its medical research. In fact, only 30% of full-time faculty indicate general agreement with this statement.

TABLE 2
Physician Attitudes toward the College of Medicine: Role and Function

	Respondent Perceptions (%)					
	Strongly Disagree	Weakly Disagree	Neutral	Weakly Agree	Strongly Agree	Unsure
<i>The College of Medicine is one of the best medical schools in Canada</i>						
All Physicians (n = 601)	9.0	16.3	26.4	20.3	14.0	14.0
<i>The College of Medicine plays a strong leadership role in shaping health policy in the province</i>						
All physicians (n = 601)	24.3	22.2	19.7	13.0	6.5	14.3
<i>The College of Medicine is committed to improving the health of the people of Saskatchewan</i>						
COM-Affiliated Physicians (n = 331)	4.8	12.2	22.1	26.3	28.9	5.7
<i>The College of Medicine has an appropriate and clearly articulated mission</i>						
COM-Affiliated Physicians (n = 331)	8.4	7.2	26.3	29.6	15.9	12.6
<i>The College of Medicine has a good reputation for the quality of its medical research</i>						
COM-Affiliated Physicians (n = 331)	17.3	18.9	24.3	21.9	5.7	11.9
<i>The College of Medicine is committed to physician manpower planning in the province</i>						
COM-Affiliated Physicians (n = 331)	26.9	24.6	17.1	13.5	3.6	14.3

Survey respondents indicate that the COM is not sufficiently involved nor committed to physician manpower planning for the Province. This is most strongly expressed by small city, town, and rural-based affiliated physicians where, not surprisingly, problems of physician recruitment and retention are most acutely felt. In fact, only about 12% of survey respondents who reside and practise outside of Saskatoon or Regina, believe the College is sufficiently committed to physician manpower planning for the Province. This aligns to the views expressed by senior administrators from rural Health Districts.

6.2.3 Physicians' Attitudes Toward the COM: Funding and Management

Saskatchewan's physicians were asked to indicate the extent to which they are in agreement with a number of normative statements concerning the management and leadership of the COM (Table 3). When asked about their degree of agreement to the statement that the College is appropriately funded to carry out its mandate, an overwhelming majority of survey respondents indicate that it is not appropriately funded. While 74% of affiliated physicians believe that the College requires additional resources, 83% of full-time faculty strongly disagree with the statement that the College receives sufficient operating funds. Results from this survey clearly show that there is a widespread belief among affiliated physicians that the College does not receive enough funds to carry-out its mandate.

One of the most troubling findings concerns perceptions of the overall management of the COM. Almost one-half of the College's affiliated physicians do not agree with the statement that the College is well-managed. In fact, over 60% of the COM's full-time faculty disagree with the statement that the College is well-managed, with almost 38% strongly holding the opinion that the College is not well-managed.

What seems clear from the results of this survey is that a strong majority of respondents firmly believe that the COM is neither well-funded nor well-managed. However, less clear is the nature of the impact that a perceived funding shortfall can have on both the perceptions and realities of the quality of management and leadership of the COM. These factors are, of course, inextricably linked. Critical or prolonged financial restraint can severely compromise efficient operations as organizational members and subunits increase their conflict in pursuit of diminished resources. Whether the deficiencies identified with College management are actually valid, or merely an artifact of persistent under-funding, can not be ascertained through this research alone.

6.2.4 Physicians' Attitudes Toward the COM: Relationship with Key Stakeholders

Like any organization pursuing excellence, the COM must forge strong linkages with its key stakeholders. To do otherwise would severely compromise its Mission and threaten its legitimacy as a viable organization operating in the public domain. The interdependent nature of organizational action requires the adoption of a variety of mechanisms to collaborate, influence, manage, and coordinate the interactions with key stakeholders.

Table 4 illustrates perceptions by Saskatchewan physicians on the quality of working relationships with the COM's key stakeholders.

TABLE 3
Physician Attitudes toward the College of Medicine: Management and Funding

	Respondent Perceptions (%)					
	Strongly Disagree	Weakly Disagree	Neutral	Weakly Agree	Strongly Agree	Unsure
<i>The College of Medicine is appropriately funded to carry out its mandate</i>						
COM-Affiliated Physicians (n = 331)	58.1	15.6	6.9	1.8	1.2	16.4
Saskatoon-based Affiliated Physicians (n = 208)	64.3	16.4	5.3	1.5	0.5	12.0
Regina-based Affiliated Physicians (n = 83)	43.4	15.7	12.0	1.2	2.4	25.3
Town & Rural-based Affiliated Physicians (n = 40)	57.5	12.5	5.0	5.0	0.0	20.0
COM Full-time Faculty (n = 88)	83.0	4.5	2.3	1.1	0.0	9.1
<i>The College of Medicine is well-managed</i>						
COM-Affiliated Physicians (n = 331)	28.1	19.4	21.5	10.7	4.5	15.8
Saskatoon-based Affiliated Physicians (n = 208)	37.5	21.2	18.3	8.2	4.3	10.6
Regina-based Affiliated Physicians (n = 83)	13.3	8.4	26.5	15.7	4.8	31.3
Town & Rural-based Affiliated Physicians (n = 40)	12.5	32.5	27.5	12.5	5.0	10.4
COM Full-time Faculty (n = 88)	37.5	22.7	20.5	6.8	10.2	2.3

Although there are a large number of stakeholders or constituencies with which the COM must effectively interact on a continuing basis, one of its most critical is with the Saskatoon Health District. Since much of its service, education, and research Mission is delivered in conjunction with the Saskatoon Health District, the overall quality of this key relationship is paramount to the success of the Mission of the COM. Nevertheless, almost one-half of Saskatoon-based affiliated physicians indicate that the COM does not have a good working relationship with the Saskatoon Health District. When full-time faculty of the COM are asked about the quality of the relationship between the COM and the Saskatoon Health District, only 15% indicate that they believe the COM and Health District have a good working relationship.

TABLE 4
Physician Attitudes toward the College of Medicine: Relationship with Key Stakeholders

	Respondent Perceptions (%)					
	Strongly Disagree	Weakly Disagree	Neutral	Weakly Agree	Strongly Agree	Unsure
<i>The College of Medicine has a good working relationship with the Saskatoon Health District</i>						
COM-Affiliated Physicians (n = 331)	19.4	12.6	17.8	10.8	5.5	33.9
Saskatoon-based Affiliated Physicians (n = 208)	28.9	19.7	20.2	12.0	4.3	14.9
COM Full-time Faculty (n = 88)	33.0	20.4	22.7	6.8	8.0	9.1
<i>The College of Medicine has a good working relationship with the Regina Health District</i>						
COM-Affiliated Physicians (n = 331)	9.2	9.8	18.5	7.7	2.2	52.6
Regina-based Affiliated Physicians (n = 83)	17.1	19.5	24.4	18.3	4.9	15.8
<i>The College of Medicine has a good working relationship with the DHA in which I reside and/or practice</i>						
Small City, Town & Rural Physicians (n = 176)	24.4	13.1	19.9	14.8	9.1	18.7
Town & Rural-based Affiliated Physicians (n = 42)	26.2	19.0	23.8	11.9	14.3	4.7
<i>The College of Medicine has a good working relationship with the Saskatchewan Medical Association</i>						
COM-Affiliated Physicians (n = 331)	7.5	12.9	21.6	15.3	6.3	36.4
COM Full-time Faculty (n = 88)	14.8	17.0	17.0	18.2	4.5	28.4
<i>The College of Medicine has a good working relationship with the Saskatchewan College of Physicians and Surgeons</i>						
COM-Affiliated Physicians (n = 331)	2.1	8.7	21.6	18.6	8.7	40.3
COM Full-time Faculty (n = 88)	3.4	10.2	25.0	27.3	9.1	25.0

Perceptions of problems with the quality of working relationship are not only found in the College's relationship with the Saskatoon Health District, but are also believed to be a factor in the College's relationships with other Health Districts. In fact, 37% of Regina-based affiliated physicians indicate that the College does not have a strong working relationship with the Regina Health District. When physicians as a whole were asked to assess the quality of the relationship of the COM with the Health District in which they reside, only about 21% agree that the current relationship is effective. There is a widespread opinion among affiliated physicians that relationships with provincial Health Districts remain problematic for the COM.

When asked to assess the quality of the working relationship between the College and the SMA, about 20% of COM-affiliated physicians indicate that they believe the College does not now enjoy a good working relationship. It should be noted, however, that a large percentage of respondents indicate that they are unaware, unsure, or not able to comment on the overall effectiveness of this relationship.

The quality of the working relationship between the COM and the CPSS is generally perceived as being effective by many respondents. However, again it should be emphasized that a large number of respondents were unable to assess the quality of the College's relationship with the provincial CPSS.

In the interpretation of the overall quality of the working relationship between the College and its key stakeholders, it should be remembered that the factors or forces underlying the relationship have not been clearly elucidated. Although one can say something about the perceptions that Saskatchewan's physicians hold on the quality of relationship of the College with its key stakeholders, using this research method we are unable to identify those factors or forces that directly contribute to the quality of these relationships.

6.2.5 Physicians' Attitudes Toward the College of Medicine: Medical Education

Saskatchewan's physicians were asked about the quality of the medical education provided by the COM (Table 5). On balance, the COM is perceived as providing a high quality of UGME, PGME and continuing medical education. Almost two-thirds of respondents indicate that they believe the quality of UGME provided is of very high quality; about 47% of respondents agree that the COM's PGME is of very high quality; while more than 53% agree that its continuing medical education is of very high quality.

Graduates of the COM were asked about their overall level of satisfaction with the quality of education they received. On balance, College graduates indicate a high to very high level of satisfaction with their education: 86% of graduates are satisfied with their preparatory education in basic clinical sciences; 93% are satisfied with their preparation in clinical skills; 86% are satisfied with the relevance in their education content; 86% satisfied in the quality of their instructors; and about 70% are satisfied with their treatment as a medical student. Recent College graduates also report a high level of satisfaction with the overall quality of education received from the College and were not found to be significantly different in their responses from those who had graduated before 1988 (Table 6). Fortunately, the effects of the housestaff strike in 1995 does not appear to have adversely influenced the educational satisfaction of trainees.

TABLE 5
Physician Attitudes toward the College of Medicine: Medical Education
All Physicians (n=601)

	Respondent Perceptions (%)					
	Strongly Disagree	Weakly Disagree	Neutral	Weakly Agree	Strongly Agree	Unsure
<i>College of Medicine provides a very high quality of undergraduate medical education</i>	1.3	7.4	16.5	29.2	34.4	11.2
<i>The College of Medicine provides a very high quality of postgraduate medical residency training</i>	5.0	14.0	21.2	32.7	14.2	12.9
<i>The College of Medicine provides a very high quality of continuing medical education</i>	7.7	14.0	20.8	35.4	18.0	4.1

More problematic with respect to the attitudes of graduates and the quality of the education provided by the College, 22% of respondents indicated that they were not satisfied with the financial assistance provided. This is particularly acute in more recent College graduates where about 34% express some level of dissatisfaction. It should be noted, however, that there has been a significant increase in the cost of university education in recent years, with a larger proportion of that cost being borne by the student. This trend is consistent in medical schools across Canada and reflects a national trend to "re-balance" cost-sharing, by requiring students to pay more. Increasingly, students appear to find it difficult to finance the cost of UGME, during a lengthy period of training in which income has been deferred. This also potentiates the desire for high income upon completion of studies and in the formative years of practice. Arguably, this may influence practice behaviours and volumes.

About 30% of graduates indicate a level of dissatisfaction with their current relationship with the College. It is unclear from this what aspect or aspects of their current relationship with the College are unsatisfactory. This requires additional follow-up to determine why many graduates remain unsatisfied. Such work is well worthwhile as a component of rebuilding the COM's image.

When PGME training is assessed, about three-quarters of residency graduates indicate satisfaction level with the quality of their residency training, though this is not high among recent graduates. When PGME graduates are asked about their treatment as residents by the COM, about 23% indicate some level of dissatisfaction. This rises to about 38% when considered from the perceptions of recent graduates.

TABLE 6
Graduate Physician Attitudes toward the College of Medicine: Medical Education

Level of Satisfaction with:	Respondent Perceptions (%)					
	Very Dissatisfied	Somewhat Dissatisfied	Neutral Satisfied	Somewhat Satisfied	Very Satisfied	Unsure
<i>Preparation in basic medical sciences</i>						
All Graduate (n = 257)	1.6	4.7	8.2	37.5	48.0	0.0
Recent Graduate [1988-1997] (n = 61)	1.6	6.6	8.2	39.3	44.3	0.0
<i>Preparation in clinical skills</i>						
All Graduates (n = 257)	0.0	4.7	2.3	36.2	56.4	0.4
Recent Graduates [1988-1997] (n = 61)	0.0	6.6	4.9	32.8	54.1	1.6
<i>Relevance of education received</i>						
All graduates (n = 257)	1.2	6.2	6.6	49.4	36.6	0.0
Recent Graduates [1988-1997] (n = 61)	3.3	9.8	4.9	54.1	27.9	0.0
<i>Quality of instructors</i>						
All graduates (n = 257)	0.4	5.4	8.6	52.5	33.1	0.0
Recent Graduates [1988-1997] (n = 61)	0.0	6.5	13.1	52.5	27.9	0.0
<i>Financial assistance provided</i>						
All graduates (n = 257)	9.3	12.9	32.0	21.9	13.8	10.1
Recent Graduates [1988-1997] (n = 61)	13.6	20.3	27.1	20.3	3.4	15.3

TABLE 6 cont'd
Physician Attitudes toward the College of Medicine: Medical Education

Level of Satisfaction with:	Respondent Perceptions (%)					Unsure
	Very Dissatisfied	Somewhat Dissatisfied	Neutral Satisfied	Somewhat Satisfied	Very Satisfied	
<i>Treatment as a medical student</i>						
All Graduates (n = 257)	4.7	17.2	8.6	37.5	32.0	0.0
Recent Graduates [1988-1997] (n = 61)	6.5	19.7	9.8	41.0	23.0	0.0
<i>Current relationship with College</i>						
All Graduates (n = 257)	15.8	14.1	36.2	21.3	10.2	2.4
Recent Graduates [1988-1997] (n = 61)	18.3	11.7	43.3	16.7	5.0	5.0
<i>Quality of residency training</i>						
All Residents (n = 170)	0.6	12.4	8.8	34.1	40.6	3.5
Recent Residents [1988-1997] (n = 54)	1.9	20.4	11.1	33.3	29.6	3.7
<i>Treatment as a resident</i>						
All Residents (n = 170)	9.0	13.8	8.4	31.1	35.3	2.4
Recent Residents [1988-1997] (n = 54)	18.9	18.9	7.5	28.3	24.5	1.9

On balance, the results of this research suggest that College graduates hold a high level of satisfaction with the overall quality of their UGME and PGME. However, recent residency graduates report a higher level of dissatisfaction with the quality of their residency training, as well as their perceived treatment as a resident by the College. Again, it should be noted that we are unable to derive definitive conclusions from this research concerning which aspects of the residency experience that many recent graduates find unsatisfactory. The College needs to take additional steps to discover the root causes of this dissatisfaction as the first step to rectifying them.

6.2.6 Attitudes of Saskatchewan's Physicians: Satisfaction with the Medical Care System

The attitudes of Saskatchewan's physicians were assessed with respect to their level of satisfaction with their practice of medicine in the Province (Table 7). While more than nine out of ten respondents indicate that they are either satisfied or very satisfied that they chose to become a physician, most respondents are far less satisfied with many features of the medical care system in Saskatchewan.

Using a five-point Likert scale (1 = very dissatisfied and 5 = very satisfied), survey respondents were asked to indicate their overall degree of satisfaction with existing conditions and constituencies.

While respondents generally report a higher degree of satisfaction with the quality of medical care they provide as well as their overall quality of life in Saskatchewan, they are much less satisfied with a number of other things. Perhaps not surprisingly, physicians report a high degree of dissatisfaction with the level of health care funding, progress in health care reform, as well as a degree of dissatisfaction with the provincial fee schedules. On balance, satisfaction level with the COM produced a score of 2.73, leaning slightly to an overall level of satisfaction.

TABLE 7
Attitudes of Saskatchewan Physicians: Satisfaction with the Medical Care System*

Variable	Mean	S.D.	N
Your degree of satisfaction with: Quality of care you provide patients	3.91	.86	579
Saskatchewan Medical Association	3.59	1.04	575
Overall quality of life	3.50	1.21	585
Canadian Medical Association	3.36	.92	570
College of Physicians & Surgeons	3.03	1.06	577
Financial remuneration	2.79	1.24	585
College of Medicine	2.73	1.03	569
Provincial fee schedule	2.63	1.19	564
Saskatchewan Health	2.56	1.03	565
Health reform in Saskatchewan	2.15	1.04	580
Level of health care funding	1.85	.94	582

*Note: from "1"= very dissatisfied to "5"=very satisfied

TABLE 8
Correlational Analysis*
Attitudes of Saskatchewan Physicians: Satisfaction with the Medical Care System

Variable	1	2	3	4	5	6	7	8	9	10	11
Your degree of satisfaction with:											
1. Quality of care you provide patients	1.00	.15	.27	.11	.16	.14	.18	.16	.33	.24	.21
2. Saskatchewan Medical Association		1.00	.20	.55	.27	.20	.15	.24	.12	.05	.01
3. Overall quality of life			1.00	.06	.23	.31	.10	.27	.28	.31	.22
4. Canadian Medical Association				1.00	.33	.15	.22	.19	.21	.15	.08
5. College of Physicians & Surgeons					1.00	.24	.27	.26	.32	.31	.21
6. Financial remuneration						1.00	.16	.75	.27	.26	.33
7. College of Medicine							1.00	.13	.23	.18	.19
8. Provincial fee schedule								1.00	.33	.28	.39
9. Saskatchewan Health									1.00	.57	.52
10. Health reform in Saskatchewan										1.00	.57
11. Level of health care funding											1.00

*Correlations greater than .11 are significant at $P < .01$ and greater than .15 are significant at $P < .001$.

To answer the question of whether the level of satisfaction with the COM is associated with the extent of satisfaction with other conditions and constituencies, bivariate correlational analysis was performed. The result of this analysis constitutes Table 8. These findings variously suggest positive and significant levels of association. There is also some evidence to suggest that physicians reporting higher levels of dissatisfaction with the COM are more likely to report higher levels of dissatisfaction with a variety of other factors.

Confirmatory factor analysis indicates that respondents are able to distinguish their level of general dissatisfaction (or satisfaction) against other factors such as their level of financial remuneration, overall quality of life in the province, their financial remuneration, or the progress of health care reform in Saskatchewan.

6.2.7 Conclusion

Although there is substantial variation with respect to attitudes that Saskatchewan's physicians hold in regard to the COM, a number of conclusions can be drawn from the results of this research. While many survey respondents generally perceive that the College has, or ought to have, an appropriate and clearly articulated Mission and is committed to improving the health of the people of Saskatchewan, a majority suggest that the College needs to take a proactive role in providing more active leadership in shaping health policy in the Province, including medical manpower planning.

Many respondents also indicate that the College, as presently constituted, is neither well-managed nor well-funded, although one is unable to ascertain the nature and extent of the interdependence between chronic or severe under-funding and the perception of management effectiveness.

Physician respondents report that the COM needs to establish more effective working relationships with provincial Health Districts including, most notably, the Saskatoon Health District.

On balance, respondents report a favourable attitude toward the quality of educational offerings, including UGME, PGME and continuing education. However, recent PGME graduates report less satisfaction with the overall quality of their residency programs, than do earlier graduates.

As a component of the survey, there were many textual and qualitative comments. These were highly congruent with the input from interviewees, particularly those from Saskatoon. It should be remembered that any interpretation of the findings from this research must be qualified by several factors. Firstly, these findings represent the subjective perceptions of individuals who have various associations with and to the COM. Secondly, these findings reflect attitudes and opinions which may be highly transient in nature. Thirdly, attitudes held about the COM may be conditioned by a host of other factors. For instance, general dissatisfaction that one holds about the quality of medical practice in Saskatchewan or level of financial remuneration, progress on provincial health reform, or any other factor may predispose to viewing the COM more harshly, if it is believed that these factors impact negatively on the ability of the College to fulfill its mandate. Finally, it is important to be cognisant that results of this survey reflect the attitudes, beliefs, and opinions of only one stakeholder, albeit a critically important one: the Saskatchewan physician.

7.0 ANALYSIS, SOLUTION AND THERAPEUTICS

7.1 Governance, Relationships and Affiliations

Medical schools in Canada vary significantly in how they are organized and their relationships to faculty, hospitals, health authorities and government. A changing environment of education, research, clinical practice, and funding are motivating medical schools to examine their organizational structures and consider alternatives better suited for the changing environment.

Refining a conceptual model or framework is the necessary first step in the organizational restructuring of Canadian medical schools. Organizational models flow out of contemporary academic organizational theory and case study of existing medical schools and their relationships with stakeholders in the general health care environment. Conceptual models for academic medicine provide decision-makers a framework in which to examine current and proposed organizational forms, within the mix of structural possibilities.

7.1.1 Models of Medical School-Delivery System Organization

Culbertson et al (1996) expand on a concept developed by the AAMC's Advisory Panel on the Mission and Organization of Medical Schools.⁶ They present four archetypal typologies for current and evolving organizational forms which describe the relationship between medical schools and the health care delivery system (clinical enterprise).

Type I - Single Ownership: Integrated Delivery System with Common ownership of Medical School and Clinical Enterprise

The school or parent university is the dominant actor in an integrated delivery system or clinical enterprise. A leader in this model functions as the leader of both the academic and clinical enterprise, and exercises direct executive authority over the organization. Major strategic decisions are made at the level of the board, with significant input from this unitary leader, and as a result, integration of the academic mission and the objectives of the clinical enterprise are facilitated. The chief executive's role contains that of the traditional Dean or Vice President, including responsibility for the academic mission and the business operations of the integrated delivery system. The leadership is empowered to appoint chairs of academic departments and chiefs of clinical services. Faculty physicians are typically aligned with the health system through employment agreements or contracts in addition to their academic appointments. The system can establish budgets for each of the operating units and all affiliates.

The advantages of the Type I model rest primarily in the centralization of ownership and decision-making authority. The structure is relatively flexible and responsive to organizational and environmental change. There is the possibility of significant financial advantage to the organization and its academic mission. There is the ability to merge and balance the missions of various organizations and a central executive function may emerge that allows rapid response to organizational change.

The medical school does, however, face significant financial exposure for operating a large commercial enterprise, of which only a small portion is intimately involved or necessary for academic purposes. The capital requirements to establish unitary ownership are significant. Such an organization may be legally complex in a public institution requiring the creation of new governance forms that may impinge on the powers traditionally held by the public sector. There is also a danger that this organization may be too restrictive and focused on internal affairs and place too much emphasis on strategy or operations.

Type II - General Partner: Open Delivery System, Dominated by Academic Control

The school or university is a partner and must relate to other related clinical components of the delivery system. Power and authority may be obtained, for example, by board membership on other delivery system organizations. Rather than relating to a single, unified delivery system, a Type II school will interact with a number of partners in a more open system. The leader of the

medical school will continue to control the appointment of academic department chairs and may have veto power over the appointment of clinical chiefs in other provider organizations. Physician services are delivered by full-time faculty and by community physicians who are obligated to the delivery system by contract. Some will have medical school faculty appointments. The medical school leader participates in budgeting and other operational activities for the delivery organizations, often exercising major influence. In addition, the academic leaders control faculty appointments and the medical education budget of the broader organization.

In the case of considerable operating authority for the clinical component placed with leaders outside of the school, the exchange the school receives will be weighted more toward financial support than toward governing authority. The model's structure is based on complex inter-relationships negotiated between the member organizations, with central governance placed in the hands of a coordinating entity, such as a foundation or common boards.

A major variable in this model is the relationship of the faculty practice plan(s) and the relationship between the school and the primary teaching hospital.

Type II models are advantageous to medical schools because the system is dominated by academic interests and therefore may be more supportive of traditional academic objectives and values. The systems units are also likely to have a common vision, which can lead to greater responsiveness.

The model is disadvantageous as the level of academic control may cause academic considerations to outweigh and compromise good business strategies or community interests. There is a lack of central control for contracting.

Type III - Limited partner: Open Delivery System, Dominated by Clinical Control

The school or university is recognized as a partner with other members of the open-ended delivery system and the academic organization may own and operate some clinical resources that are part of the overall clinical enterprise. In some cases, the university leaders exercise a vote as a board member within a loosely organized network. The model here is that of a consortium, in which democratic decision-making will typically prevail. The vote or influence of the academic partner is not dominant in this model and is subordinated to that of the other partners. The school or university's interests may have lower priority than the interests of related clinical entities. Academic leaders appoint academic department chairs and are consulted on appointment of clinical chiefs at affiliate organizations. Services are delivered by faculty and by affiliate faculty who have medical school appointments.

The school's capital requirements are those of a limited partner and are modest because major risk for clinical performance rests with the partner organizations. Their financial contribution to the academic mission is limited because the school makes limited capital contribution to the system. Clinical faculty, with and without faculty appointments, are likely to practice in the same organization and the school is unlikely to receive clinical revenue beyond a "Dean's tax" from the faculty practice. The extent to which the school benefits will depend largely on where the faculty practice plan is located within the organization.

The model is advantageous for the medical school, as there is limited financial exposure by virtue of limited and specific roles in clinical activities. The model combines democracy with the potential for less bureaucracy, through a predefined structure for decision-making, and the school may exercise limited veto power. Each partner can set priorities, goals, and objectives independently and each partner is able to express the organizational culture best suited to its mission and goals. Coordination results from the mutual adjustment of members, encouraged by institutional liaisons and an integrating manager.

The model is disadvantageous for the medical schools as each partner can set priorities, goals, and objectives independently and there is no presumption that partners will have common objectives. There is no single, unified planning, and no individual or group may exert enough power or influence to establish coordinated goals. Human relations problems associated with the ambiguity of structure may arise.

Type IV- Subsidiary (Wholly Owned): Fully Integrated (Closed) Delivery System, Dominated by Clinical Control

In this model, the medical school is owned by another entity (typically a foundation or health care system) and its role in governance is limited to that of a subsidiary organization. Academic leaders are not system leaders and the school supports the broader mission and goals of the overall organization. The delivery system exerts the greater influence, and the school, like other components of the system, must negotiate with the parent system for its budget allocation. The medical school leader is likely to appoint clinical chairs and may be consulted on the appointment of clinical chiefs for delivery system organizations. Faculty physicians will be employed throughout the integrated delivery system; some, but not necessarily all, will have medical school faculty appointments. It is presumed that the primary activity of the unified organization will support the education and research missions of the medical school in the system and will seek to protect the academic mission in order to protect the basic asset.

The model is advantageous as the school faces minimal capital requirements and financial exposure and legal complications are minimal.

However, the performance of the system will directly and immediately affect the school's viability. In addition, the school has limited potential, beyond the clinical enterprise, for producing additional revenues to support its mission other than receiving external research dollars.

For any medical school, there must be an appropriate role and set of relationships to allow for sufficient strategic involvement to sustain its missions. One of the keys to choosing a model or organizational relationship is to balance financial control and financial risk in a manner that supports the school's Mission.

7.1.1.1 Case Studies

Benchmarking of "best practices" is critical to organizational change. Many of the pressures of health care reform are shared by Canadian and American medical schools, though American schools have had to more aggressively and promptly respond to external change. A critical review of the approaches taken by American medical schools, in a benchmarking exercise, is important if we are to consider adapting successful models and avoid making the same

mistakes that other schools have.

To understand the diversity of approaches taken by American medical schools in organizational restructuring and partnership formation with the clinical enterprise, an AAMC working group interviewed representatives of nine medical schools in the US, selected to represent a cross section of US medical schools.⁵ This case-study approach illustrates the variations in nature, and scope of the relationship of the clinical enterprise to the education and research mission of the medical school, and provides options and models for the restructuring of Canadian medical schools.

University of Pennsylvania

The entire university health sciences enterprise is under the leadership of a single person who has the title of system CEO and medical school dean. This person reports directly to the university president.

University of Michigan

The medical school Dean and University Hospital Director both report to the University President. A position of CEO of the clinical system (to whom the dean and hospital director reports) was created as part of the institutions' reorganization, but to date the position has not been recruited or filled.

Southern Illinois University

The medical school dean also holds the title of Provost. As a community-based school, the hospital and clinical entities to which the school relates are led by officials who are independent of the medical school.

Texas A&M

The COM has a Dean as a leader. The University's Health Science Center has a separate position for a "vice-president for health affairs and executive director." At present, the dean and vice-president/executive director roles are held on an interim basis by the same person. The College's major clinical affiliate, the Scott and White Clinic and Hospital, have leaders who are independent of the University.

University of Cincinnati

The Dean of the COM reports to the University's Senior Vice-President and Provost for Health Affairs. The University Hospital Director also reports to the Senior Vice-President and Provost. The newly-formed clinical delivery network, of which the COM and University Hospital are a part, is governed by elected leaders, drawn from the participating institutions. The Senior Vice-President has been selected to serve as "Vice-Chair" of the network.

Pennsylvania State University

A single person holds the titles of Dean, System CEO (meaning responsibility for the University

hospitals), and Senior Vice-President: this person reports directly to the University President.

Dartmouth Medical School

The medical school Dean also has the title of "Vice-President" and reports to the COM Provost. The school's major affiliates each have their own presidents, with physician-elected governance. Joint boards also relate to the school, hospital and clinic.

Creighton University

The medical school Dean reports to a University Vice-President for Health Sciences, who in turn reports to the University President. The CEO of the schools major affiliate reports to officials within the for profit system that owns the hospital.

UCLA

The medical school Dean also serves as Provost for Medical Sciences, with oversight responsibility for the university-owned portion of the school's clinical delivery system. The Dean/Provost report to the campus Executive Vice-Chancellor.

Joint Planning

All schools and systems have established combinations of both governing and advisory boards to oversee delivery system issues. In some cases, academic leaders are appointed by virtue of position and have leadership roles and veto power; in other cases they hold elected or ex-officio positions and do not have a majority of board seats. Texas A&M and the Scott and White Hospital and Clinics have a harmonious relationship in which the Department Chairs of the school also serve as the Chiefs of Service at the Scott and White. Cincinnati participates in the governance of the new system with a minority of seats on the controlling bodies.

Role in Graduate Medical Education

Institutions that have changed their leadership structures so that the hospital and the school function under a single Chief Executive have the most control of PGME. In some of the evolving networks, the University continues to have primary responsibility for PGME programs, as a stipulation of the merger of the school and the University Hospital into a larger not-for-profit hospital system. At Creighton, the Dean will receive funding through the hospital to employ residents and fellows. In other cases, Department Chairs continue to manage the selection of residents and internal educational content of PGME, while their hospital partners have responsibility for other aspects, including administrative and financial affairs.

New Pressures on the Relationships Between Medical Schools and the Teaching Hospitals

Personal rapport between institutional leaders is a critical factor for success in all of the relationships studied. The role of the Dean or the Chief Executive of the Medical Center, compared with the role of the Director or Chief Executive for the integrated delivery system, has been an issue for the schools that are making changes to the delivery structures. This issue has been less pointed in the schools that are adding or changing delivery partners, but are not

developing new or unified structures. Three of the schools that are developing new structures have resolved many of the potential tensions between the school and the hospital, by appointing a single Dean-CEO who directly managed both the school and the hospital.

7.1.2 College of Medicine and University of Saskatchewan

The relationship between the COM and the UofS, through its Executive and Board of Governors, exhibits a number of dysfunctional features and characteristics and lacks the necessary level of common understanding and demonstrable accountability so as to ensure that the UofS can discharge its responsibilities to the Province and, correspondingly, that the COM can benefit from necessary and justifiable governance and management support and the strategic direction that it requires.

At one level of consideration, the COM is like any one of the other professional schools in the University, with its wide array and scope of departments, special centres, and initiatives. From this reasoning, it follows that there is concern for setting precedent in having specific governance and management infrastructure, and processes to deal with what might well appear to be one other professional discipline. This logic is flawed and threatens the central Mission of the COM.

While it is widely viewed that the COM has not sufficiently clarified its Vision and Mission it is, nonetheless, quite clear that teaching and research are the fundamental cornerstones of the COM's Mission, and are in complete congruence to the broader University Mission. However, from a broader perspective, teaching and research are actually the means of achieving the COM's ends. The ends, presumably, for all medicine schools and indeed the health care service delivery system, is to improve the health and health care of Canadians. Accordingly, the University must recognize that the COM carries a substantial role in health care delivery, with an inextricable linkage to tertiary service provision, and through this and other means, a commitment to a broader social contract with the Province and its people.

In certain respects, the COM naturally and expectedly grows outside of the walls of the traditional university. This, of course, questions the appropriate nature and relationship of the university to the medical school, a relationship which by-and-large has not been seriously and systematically considered within the context of new Canadian realities. These new realities have been brought on by the triple threat and challenges of affordability, appropriateness and accountability; in short, affordability speaks to choices about how to allocate scarce resources, which are determined in some systematic and prioritized way; appropriateness is doing the right thing for the right person or circumstance, at the right time; and, accountability speaks to being transparent, just and having understandable due process with contingent responsibilities, controls and reporting relationships in an environment in which information is provided to those that need it, in accordance with expectations derived from roles and responsibilities.

Canadian medical schools have felt the effect of government responses to affordability of public and social programs sponsored by federal and provincial budgets. Medical Schools have accordingly been challenged by fiscal restraint, downsizing and often the loss of valued personnel or reduction in morale of those that continue in new or more exacting positions. The appropriateness 'movement', of course, calls into question much of what we do and portends an evidence- and values-based approach to justifying what is or isn't appropriate. This too has

challenged the COM to produce certain types of graduates, with preparations and abilities to meet new needs for a flexible and poorly understood future. The appropriateness movement, of course, has correspondingly affected health service delivery systems and has brought about revolutionary changes in clinical practice and the expectations and accountability associated with these. It has influenced a fundamental change in the service delivery system to an ambulatory shift. Correspondingly, there has been a need to shift the educational focus to incorporate the full continuum of health services delivery, and health research focus to include policy research, health services and outcomes research, program evaluation, economic analysis etc. Finally, accountability has forced reconsideration of traditional structures, reporting relationships, balance of responsibilities and alignment of power. It has raised questions about who is setting strategic direction, whose job is it to follow through, and what is the best organizational structure to achieve objectives. Again, this is challenged by the changes in the health service delivery system, as the COM responds by making fundamental changes in the job description of its critical leaders, including Deans and Academic Heads.

There is naturally an inertia or resistance to a magnitude of change of this sort. But, the external conditions and context simply require a different kind of COM, with meaningful governance and sound management processes and practices, in order to get the job done, in what can clearly be argued as being a particularly complex organizational and management challenge under current day and future anticipated circumstances.

The University does not have, and never has had, a comprehensive understanding of the financial resources, or strategic direction of the COM. This is in part explained by the fact that the revenue stream through Post-Secondary Education to the University, and subsequently to the COM, accounts for only 22% of total funding. Accordingly, there is no comprehensive budget approval, financial reporting, and comprehensive financial understanding of the COM. These and other factors have led to the reality and belief that there is systemic under-reporting by the COM and correspondingly, poor understanding of the COM's total financial picture, its exigencies, its flexibilities and its commitments. What comes out is the dichotomous view of a constant need for more unnecessary information and reporting versus a perspective that information is unwillingly provided and accountability is selective and unnecessarily narrow. This leaves current University Executives, such as the V-P Academic or Finance, feeling largely as if they are observers of a relationship between Saskatchewan Health and the COM. Further, it provides difficulty in assessing information which is provided, in what appears to be a selective and discretionary fashion, rather than through free and open communication. In short, this practice undermines trust.

However one describes it, there is a significant "distance" between the COM and its operations, and the Executive and Board of the UofS. The current reality appears to be that the COM's business which crosses University executive desks is more often than not a reactive management agenda - once there is a problem, or because there are already consequences from a previous course of action. In short, this causes ill-will and misunderstanding. Therefore, both the Executive and University Board must move to occupy this distance and to provide effective governance for the COM. This portends an approach where strategic direction is clear, accountabilities are understandable and transparent, and the structures and processes that are in place are meant to enable the complex interplay between long-term vision and the daily exigencies of operations and management, within a context of mutual respect. Accordingly, we would urge that the UofS consider the COM as having a unique nature that

necessitates the creation of structures and processes to increase governance and accountability of the COM.

7.1.3 College of Medicine and Health Districts

7.1.3.1 Saskatoon Health District

The unprecedented structural change in the provision of publicly funded health care services and, in particular, changes in Saskatoon, Regina and other Districts, have forced more cross-sectoral thinking in health services delivery and has made more apparent, if not perpetuated, resistance by the COM's team participation in certain aspects of health service delivery. Furthermore, both financial transparency and parsimony have reduced the desire and support for cross-subsidization of academic activities from clinical service revenues, whether through CPPs or subsidization by Saskatoon Health District. This has substantially reduced the flexibility that the COM has formerly enjoyed, when there was more direct and personal contact between Deans and CEOs of the Royal University Hospital. In short, when there was tight alignment between the goals and objectives of the COM and health service delivery system. The service delivery system is now regional and cross-sectoral. Regrettably, the COM is not. In fact, it remains quite firmly entrenched, largely in a single institution on campus. It is believed by some that this is the only viable option for future sustainability of the COM. What is often described as the two solitudes, the COM and the District, compete in health services delivery, and in a corresponding manner have competing goals and objectives.

Both the perception and the reality of two solitudes has got to be squarely faced as a critical factor in the COM's future viability. Indeed, we would suggest this is similarly central to the future quality of the service delivery system. The malalignment of goals and objectives and the absence of common Vision and Mission shared by Saskatoon Health District and the COM simply has to be reconciled. If indeed there is an unbending and narrow interpretation that the Vision of the COM is teaching and research as 'ends,' as opposed to means, then there will continue to be problems with malalignment of goals and objectives. Teaching and research are the fundamental means that the COM has to achieving its ends, better health for Saskatchewan's people. Correspondingly, the Saskatoon Health District provides health care which is a means, not an ends; the ends being health for Saskatchewan's people. Accordingly, we agree that it is both possible and necessary to have a common Vision for the COM and the Saskatoon Health District. Without this, there will be perpetual malalignment, and failure to achieve common purpose, with correspondingly detrimental effects on health care and the health of Saskatchewan's people.

The relationship for managing clinical services is at present particularly dysfunctional and there are frequent confusions and misunderstandings with respect to the COM's participation in health service delivery, most particularly, in the Saskatoon Health District, but also for provincial health programs. Several mechanisms to resolve these issues have been implemented, including the promulgation of an Affiliation Agreement, and the Medical Liaison and Planning Committee, alternatively chaired by Chief of Staff and Dean. This Committee has a central and important role and value in facing and resolving some of the College and District issues and problems.

The Dean is invited to attend the Senior Leadership Team's meetings (Corporate and Executive) of the Saskatoon Health District, but has not for several reasons been a frequent or effective member in that forum. Correspondingly the Physician Vice-President of Saskatoon Health District is welcomed to the Dean's Executive and the Chief of Staff to the Academic Heads' regular meetings. Both of these relationships and cross-organizational representations are extremely important. They must be taken seriously and fulfilled with impeccable attention to attendance and appropriate representation, from each of the two organizations.

Dysfunctionality in the relationship between the COM and Saskatoon Health District is further characterized by the difficulties associated with the distinction in roles and responsibilities for the Academic and Service Heads. There is a particularly poignant example in terms of representation to the Medical Advisory Committee of Saskatoon Health District, in which large departments such as Surgery and Medicine are not represented by their Academic Head. No doubt, there has been and will continue to be a host of arguments as to why the positions of Academic and Service Head should not be combined. It is the perspective of the reviewers, however, that there is more to be achieved by consolidation than separation of these roles. At this operational level, it is critical to harmonize the goals and objectives of the COM with the Saskatoon Health District, otherwise it perpetuates the two solitudes. While the dual relationship carries with it a wide scope of responsibility, which requires solid management ability and support, the reality is there are too many examples where the relationships between the COM and Saskatoon Health District are not structured for success. This is similarly true for Regina Health Districts and other Health Districts, but is less so outside of Saskatoon and Regina, when it comes to delivery of services, particularly those that are tertiary in nature.

Recommendation:

We recommend that fastidious attention be paid to attendance at senior management meetings of the Dean and the Saskatoon Health District, with the Physician Vice-President Medical Services, Saskatoon Health District, attending the Dean's Executive, and Chief of Staff, Saskatoon Health District, attending the Academic Head's meetings; and, the Dean or Associate Dean Clinical Sciences attending the Senior Leadership Team meetings of Saskatoon Health District.

Recommendation:

We recommend that consideration be given to revising the Medical Advisory Committee to achieve effective input from all clinical Academic Heads, in those cases where they are not correspondingly the Service Heads for the Saskatoon Health District.

7.1.3.2 Regina Health District

Outside of Saskatoon, Regina is unlike any other Health District. The provincial distribution of tertiary services and specialty capacity requires Regina's presence and partnership with Saskatoon in order to meet the service delivery needs for the Province. Regrettably, the

relationship between the medical establishment of Saskatoon and Regina has never been harmonious. Diversity of views on the role of Regina in relation to the COM is substantial, with some believing that the COM simply has no choice but to have a meaningful and effective presence in Regina, with others believing that this is a southern appendage that is not needed and not welcomed, lessening the strength of the COM by inappropriately diffusing its scope of operations.

The reality is that the COM continues to have a significant investment in Regina, while at the same time is perceived by many to have little if any presence. Regrettably, the Mission and Vision for Regina's involvement is particularly unclear, stemming from the overall lack of Vision and Mission for the COM. It is time to fix this problem and to get clear about what role Regina will play. Playing no role, though perhaps an option, we would argue as being untenable. The clinical practice potential and willingness of, particularly, part-time teachers is well-recognized in Regina. Thoughtful discussants need to come together and decide what that role specifically should be. What level, nature and volume of training should take place in Regina, by and for whom? Once concluded, this needs to be resourced and become a strategic element in the provincialization of the COM. Countless energies are being consumed, trying to rationalize away meaningful involvement of the COM in Regina. Finding thoughtful and enduring solutions to this festering problem alone would go a long way to improving the image of the COM, as well as the perception that the social responsibility is being more adequately fulfilled.

While not the specific focus of this Review, it does appear that Regina offers substantial potential for training the "generalist;" that is to say, clinical exposure and education which capitalizes on strong family medicine and selected specialty training such as general medicine, general surgery, etc.. This would align well to training in the junior specialty years and also be particularly fertile ground for undergraduate and postgraduate students seeking clinical exposure where there is a lesser hierarchy of house-staff and a greater opportunity to be more meaningfully involved and clinically engaged. This is by no means an argument for JURSI's or PGY1s engaging in independent practice. We are also not tendering an argument as to the best form of training being preceptorship versus CTU. What we are saying, is that there is great training potential in Regina and it should be seen as an asset to the COM, factored into strategic plans for the COM, and resourced as such. Of particular note, is the Department of Family Medicine which appears to be ideally situated in Regina and, in the opinion of the reviewers, can be the central Department around which the COM's presence is rebuilt. Regrettably, there appears to be a concern or constant threat that this will not continue in Regina. Again, this reduces the energies that could be better utilized in developing the Department of Family of Medicine.

We encourage the Department of Family Medicine to assume several areas that would be of particular value to the social contract, specifically related to offering physician assessment, upgrading, remediation services and other supportive programs which would be particularly contributory to physician retention, if not recruitment. This is further discussed in Section 9.5.1 Many rural Health Districts have urged this direction. Family Medicine should be resourced so as to achieve this.

The two solitudes discussed in Saskatoon are not nearly as apparent in Regina, likely because of the thin critical mass of full-time faculty, or other factors such as greater level of comraderie between faculty and part-time teachers. Reviewers were impressed by the potential for strong

and diligent support from part-time teachers in Regina, who seek little more than meaningful involvement and perhaps modest respect for what they do.

With the service consolidations that have taken place in Regina, it appears particularly useful to re-examine the value that Regina can have for the training program and, indeed, developments in clinical research. Regina Health District and the COM needs to achieve a higher level of understanding in a cooperative fashion, and enshrine and actualize this in an affiliation process and agreement that specifies mutual expectations and responsibilities over a sufficiently sustainable period so as to reduce the continuing uncertainty and negative consequences of it.

Recommendation:

We recommend that Regina be incorporated as a strong and continuing component of the College of Medicine's Mission. Regina's contribution to the College of Medicine should be included within the larger Vision and Mission that must be developed. This should include a clear, thoughtful understanding with respect to the roles and responsibilities that will be assumed in Regina and, furthermore, resources necessary to achieve these.

7.1.3.3 Other Districts

Beyond Saskatoon and Regina, the relationship of the COM to other Health Districts is variable, but the predominant perception of many is that it is less than favorable or optimal. Much of the perception turns on the role that the COM plays in physician recruitment and retention to rural districts. In the first instance, there continues to be questions about the appropriateness of the training for rural-bound physicians. It is felt that some trainees are ill-prepared for the rigours of rural practice and yet others argue that this is related to the solo practice approach that continues to occur in Saskatchewan. Having said this, the rural practice stream in Family Medicine is a welcome innovation and has begun to address both realities and perceptions of rural practice.

There are also criticisms of the attitude of the COM towards rural practice as being a "second-class" consideration. There is a perceived elitism coming from selected academics at Royal University Hospital that quality clinical practice ends at that doorstep. It is never easy to pin down the proof of such perceptions and, arguably, putting a lot of energy into this seems less appropriate than reversing this perception, whether it is real or imagined.

There are a number of additional irritants that the Health Districts repeatedly raise. None appears greater than the lack of access to medical school trainees and their list of contact points. It seems ironic that Health Districts wishing to recruit medical students after they graduate and, accordingly, wishing to formulate relationships as early as possible, have to elucidate the contact points for the medical students through circuitous means. Several interviewees implied that American recruitment firms, offering financial or gustatory incentives, were much more likely to get access and contact to the medical students than the relevant Health Districts of Saskatchewan. We were particularly surprised to learn that the Recruitment Coordinator, as well, is not able to gain direct access to this list. It is understandable that medical students deserve and must have protection of their personal privacy. It seems well

beyond logic, however, that absolute preservation of the medical students contact points in this day and age can be seen to be a realistic proposition, when physician recruitment and retention in Saskatchewan is such a paramount issue.

It is apparent that the earliest possible time that medical students can have contact with rural opportunities, the more likely they are to see and wish to experience the benefits of rural practice. There is no question that the current placement of second-year medical students in rural practices is welcomed by both the trainees and prospective employers. It seems obvious that this program should be extended and broadened to include experiences between first- and second-year. At this point in time, it might be particularly useful to expose these young and formative minds to a measure of sensitivity training to both clinical practice and administrative leadership, such that early in medical students' formative years, they would see role models of practising clinicians within their environment, and functioning administrators managing health services delivery. This would inculcate understanding of the necessity for harmony and mutual respect between clinical and administrative practice.

Health Districts outside of Saskatoon and Regina have other needs that relate to physician recruitment and retention. On the recruitment side, this has to do with ability of Health Districts to access upgrading for additional skills training for clinicians who may aspire to come to their Districts. Health Districts see the COM as being an obvious source of this, though lament its current incapacity to do such work. Physician support spanning the range from determination of competency to specific skills development and to re-incorporation to and monitoring in practice are required. Again, the COM is seen as a potentially important purveyor of such services and programs, but Districts lament the fact that this is currently not the case.

As another point with respect to the COM's relationship to rural Health Districts, it seems necessary to develop approaches towards improved understanding by the faculty for the exigencies of rural practice and the health and health care needs of these communities. Health Districts have suggested that faculty who have had no rural experience should be exposed to it in some meaningful form so as to raise the level of awareness. Also, Health Districts wish to meet new faculty and understand them better and want to provide opportunities to formulate relationships. By the same token, Health Districts could do more to support the COM, through selective forms of financial support or further assistance in specific aspects of undergraduate or postgraduate education, such that the COM is better able to produce physician resource requirements for the market. The time is right for these endeavors and the Health Districts appear highly receptive.

Finally, Health Districts and the physician community within them, no matter how limited the size, must engage in both quality improvement and peer review processes. This is often not easy, particularly in small Districts with a limited number of physicians. Effective peer review requires a measure of judgment but demands professional objectivity. The COM could provide such support to Districts, as and when it is necessary. This is not a suggestion to place the COM in any form of monitoring or evaluative role for physician practice. However, effective and professional peer review conducted in camera and with privileged process is a requirement for professionalism. The COM playing this role would be fulfilling a component of its social responsibilities to Health Districts.

7.1.4 College of Medicine and Government Departments

7.1.4.1 College of Medicine and Saskatchewan Health

The relation between the COM and Saskatchewan Health from some perspectives has never been a strong one, based on mutual trust and admiration. In recent times, vicissitudes associated largely with physician reimbursement and other aspects of financial consideration, have allowed relationships to deteriorate. Letters to high-ranking officials and the Premier have not helped relations. Much can be done to nurture greater mutual respect and trust in this relationship.

Saskatchewan Health does not receive comprehensive financial reporting, and the COM does not have alignment to the provincial budget and scheduling process. Requests for resources coming to Saskatchewan Health and government are sporadic and appear piecemeal and unpredictable. Saskatchewan Health sees approaches to physician payment, goals and objectives of Health Districts, and clinical plans as not being in synchrony. It also recognizes that the objectives of academic programs and the service delivery system are in conflict and require attention. Correspondingly, the COM believes there is a widespread lack of understanding of the CSF, its intentions and justifiable uses.

The COM has maintained for many years, in advance of the Kerr White Report of 1989, that it has been under-funded, particularly as it relates to compensation levels for faculty. Outside of the COM, there are further perspectives that the COM is not being provided with or seeking effective governance from the UofS and that the relationship with Saskatchewan Health has deteriorated to the point that it is more adversarial than problem-solving. While the problematique and the diagnostics are related to the aforementioned relationships, some of the issues must be examined internally with respect to management structure of the COM itself. Additionally, the COM and Saskatchewan Health must achieve new understandings with respect to the management of the CSF.

7.1.4.2 Saskatchewan Post-Secondary Education

There is no apparent significant strategic or operational linkage between the COM and Post-Secondary Education. Nor do we necessarily argue that there should be, depending, of course, on the relationship to and governance of the University. Post-Secondary Education contributes to the cost of running the medical school, through provincial budgeting going to the UofS. This represents approximately 22% of the revenues coming to the COM. Post-Secondary Education does not receive comprehensive budgeting and financial statements. Furthermore, it is not directly involved with, or particularly interested in, the service provision requirements associated with the broader social responsibilities of the COM.

The question has been raised as to whether or not all funding should come from a single source in Government. Clearly, there are arguments for and against this proposition. With most medical schools in Canada receiving funds from both Health and Post-Secondary Education, the notable exception is Memorial wherein all funds flow from Health. Interestingly enough, the position of the current Dean is that this is not optimal for Memorial, and that it limits their ability to garner additional funds that might otherwise be forthcoming from Post-Secondary Education. Contrariwise, the former Dean of Memorial believes that it is a distinct advantage to

have all funds coming from a single source, that being Health. In short, his view is that it is easier to make a valid case for resources that are often of a particularly clinical nature, to the Department of Health, as opposed to Department of Post-Secondary Education. After careful consideration of this matter, the reviewers would suggest that it seems less important that all public funding come from a single departmental source in government than there being appropriate resourcing of the COM, that comes from revenue streams transparently aligned to functions, services and programs. In other words, Health should pay for clinical services and practice while Post-Secondary Education should pay for teaching and, to a limited extent, research, at least its infrastructure. This is not currently the case, as will be demonstrated in Section 7.5.5.

Succinctly stated, there is a large body of academic activity that is not resourced at the UofS from funds received from Post-Secondary Education. In fact, we will argue that this is a sizable portion of academic activity which, in effect, is not compensated or, realistically, is being cross-subsidized from clinical practice, whether it be the CSF, CPPs or, indeed, other forms of material cross-subsidization by Saskatoon Health District, and to a much lesser extent Regina Health District, or other Special Purpose Research Funds. This is not to say that the support of Saskatoon Health District should lessen and be substituted through UofS and Post-Secondary support. However, the malalignment of revenues to roles, responsibilities and services is a particularly complex problem in the COM. This demands attention and resolution.

7.2 Management

7.2.1 Management Overview

Failing to promulgate a modern Vision and Mission for the COM, and malalignment of goals and objectives between the COM and Saskatoon Health District complicates both the internal and external management processes of the COM. In fact, this is at the heart of many of the COM's problems, both in reality and perception. Specifically, this places the Dean and the Academic Heads in a position of potential conflict or confusion as it relates to the interplay and balance between academic and service functions. While on the one hand management strategies and decisions of Saskatoon Health District may adversely affect the COM, so too, decisions made by Academic Heads, the faculty and the COM may adversely affect service provision.

Regrettably, there is a wide-ranging perception that management, organization and processes within the COM have become progressively dysfunctional. Some of this is attributable to shallow management structure in the Dean's office, with no effective second-in-charge (2IC) who may offer effective representation to the COM in the Dean's absence, or as the Dean's formal delegate or substitute for dealing with operations.

The shallow management infrastructure is comprised of two associate deans (undergraduate - 0.5FTE; postgraduate - 0.5 FTE) both of which are part-time and carry heavy, additional clinical loads. There is a part-time position accorded to Assistant Dean, Research (0.8FTE). With an organization of this size and complexity, with multiple funding sources and such a broad scope of expectations and responsibilities, attention has to be paid to strengthening the management infrastructure and processes, and the Dean's supports, so as to meet the COM's commitment to accountability.

7.2.2 Organization and Meetings

Organizational accountability needs to be strengthened by clarifying the roles of the faculty management for research, education, and clinical service. Accordingly, we believe that one full-time Associate Dean should be present for each of these functional areas. Furthermore, we believe that the Associate Dean of Clinical Services should act as the 2IC for the Dean, providing effective management interaction, in direct conjunction with the Physician Vice-President, Saskatoon Health District. It is the Associate Dean of Clinical Services that should attend the Senior Leadership Team meetings of the Saskatoon Health District and, secondarily, act as the principal point of contact for all Health Districts, unless their issues were specifically related to UGME, PGME, or research.

The Associate Dean of Education should be a full-time position. Undergraduate and postgraduate education would be aligned to portfolios of Assistant Deans, who could retain part-time roles (0.5FTE). Within this newly formed office, there should be developed stronger academic support functions related to advanced teaching methods, skills enhancement for teachers, curriculum review, continuing medical education, physician upgrade and remediation programs and psychometric and/or medical education research activities. From this office, there should be a primary contact with senior faculty positions in other health services disciplines. We would argue that there is much to be gained by consolidating selected resources, educational strategies and delivery across the Health Sciences.

The position of Associate Dean Research should be full-time and will be discussed under Section 7.3.5.

Several critically important meetings are strategic to the relationship between the COM and Saskatoon Health District. Of particular note is the Medical Liaison and Planning Committee, alternatively chaired on an annual basis by the Chief of Staff and the Dean. This Committee is central to problem-solving and collaboration between the COM and District and must thoughtfully and proactively confront the problems and strategies common to the COM and District. In fact, we respectfully suggest that, together with the Executive Committee of the COM and the Senior Leadership Team of Saskatoon Health District, the Medical Liaison and Planning Committee is central to actualizing necessary recommendations chosen for further analysis and implementation, and found in this Report.

An Affiliation Agreement has been completed between the COM and the Saskatoon Health District and it is the Affiliation Agreement that must act as the guide to the interactions of the Liaison Committee which, in turn, should act to strengthen the Affiliation Agreement and the processes pursuant to it. The currently operating arrangement with alternation between Chief of Staff and the Dean, as Chair, appears ideal. Arguably, the roles might be better fused as co-chairs, or with shorter cycle times.

To reiterate, it is critically important that the Physician Vice-President, Saskatoon Health District, continue to attend the Dean's Executive meetings, whilst the Chief of Staff must maintain attendance at the meetings of Academic Heads, chaired by the Dean. Correspondingly, the Dean or Associate Dean of Clinical Services must consistently attend the Senior Leadership Team meetings for the District. Given that service delivery will predominate the agenda for such meetings, we have made the argument to suggest that the 2IC, Associate

Dean of Clinical Services, should attend these executive meetings.

We believe that there should eventually be fusion of the roles and job descriptions for the Academic and Service Heads. This would have a corresponding effect on the Medical Advisory Committee, which currently and systematically excludes the Academic Heads from Medicine and Surgery. They chair the two largest specialty areas which have the greatest impact on resources and physician manpower. While the current MAC structure may be opportune, it should not necessarily be seen as representative under these conditions. At any rate, it would be wise to reconsider the structure and terms of MAC, if there is serious intent to pursue our suggested direction to the Academic Health District.

Returning to the Dean's office, the Reviewers are of the opinion that there are far too many direct reporting relationships to the Dean, who must take a greater role in executive management and participate actively in the establishing governance structures, as well, undertaking province-wide initiatives and public roles. Accordingly, we believe that Academic Heads should report to the Associate Dean of Clinical Services for all aspects of clinical service delivery. Furthermore, initial reporting of the Academic Heads for purposes of research, in addition to education, should be through the respective Associate Deans. These are not arguments to separate the Dean from the Academic Heads, but rather to smoothen the work processes and align accountability and responsibility, while avoiding administrative bottlenecks. While it will be clearly necessary for each Academic Head to maintain meaningful interactions with the Dean, in regards to departmental strategies and operations, most operational issues could be dealt with at the secondary level in the Dean's office, provided that the executive level meetings chaired by the Dean provide effective input and problem-solving by respective Executive and Associate Deans. This is an ideal training ground for executive development, which leads to succession planning.

We anticipate strong resistance to the suggestion of altering the direct reporting relationships to the Dean. We assume that at least some Academic Heads will believe that they do not have an effective working relationship with the Dean, if they do not report directly to this position on all aspects of departmental operations. Our counter-argument is quite simple. With at least 31 direct reporting relationships, the quantity and quality of the interactions is sufficiently limited, we would argue that more efficient, thorough reporting and accountability will be rendered through the suggested alterations in reporting. In the end, of course, the Dean is the final arbitrator of all management decisions germane to the COM. This should not be construed as meaning that the Dean ought to be the sole arbitrator.

The suggested modifications in organization structure and reporting require a strong Dean's Executive Committee which, we believe, should meet at least weekly to discuss strategic, operational and business functions of the COM. Furthermore, we would suggest that an additional high-level, advisory committee be established within the COM to deal with Planning and Priorities, as a means of providing advice to the Dean. We would advise that this consist of two Academic Heads from Basic Sciences, two from Clinical Sciences, one from Community Health Sciences, and the Associate Dean of Clinical Services. Further, we would advise that this Committee eventually meet at least quarterly, but in the beginning at least monthly, and be the central strategic planning and advisory body for the Dean. The first item on the agenda of the Advisory Committee on Planning and Priorities should be developing the process towards a renewed Vision and Mission for the COM. This particular agenda item must have meaningful

involvement by Saskatoon Health District.

Recommendation:

We recommend that the Dean's office management be restructured, establishing three full-time positions:

- Associate Dean - Clinical Services
- Associate Dean - Research
- Associate Dean - Education

For clinical services the Associate Dean would be second-in-charge to the Dean. Academic Heads would report to the Associate Dean Clinical Services for all aspects of clinical services delivery. It is understood that reporting relationships between the Academic Heads to the Dean's office should be, where possible, through the Associate Deans.

Recommendation:

The Associate Dean Research should commence an internal grant review process to strengthen grant submissions and increase the success rate for competitive research funding.

Recommendation:

We recommend that the Medical Liaison and Planning Committee be encouraged to continue with a proactive agenda, formulated to fulfill the Affiliation Agreement between the Saskatoon Health District and the College of Medicine. We further recommend that this Committee have a fundamentally important role in reviewing and implementing the spirit and intent of this Review.

Recommendation:

We recommend that the Academic and Service Heads positions for the College of Medicine and Saskatoon Health District be integrated, so as to have a single incumbent chosen for both academic achievement and respect amongst clinicians, and ability to manage clinical services.

Recommendation:

We recommend that the Dean revitalize his Executive Committee to include the new management positions, meeting on a weekly basis, with an aggressive and proactive agenda to reshape the College of Medicine, congruent with this Review.

Recommendation:

We recommend that the Dean establish a Planning and Priorities Committee to provide senior-level advice of a strategic nature to the Dean and Executive. The positions for the Planning and Priorities Committee should be subjects of election from the faculty, with two positions from Basic Sciences, two from Clinical Sciences, one from Community Health Sciences and one being the Associate Dean Clinical Services.

7.2.3 Business Functions

Business functions and operations management within the COM requires renewal, and modernization, including appropriate budget development and approval processes, as well as regular financial reporting and review. Our suggestions and recommendations, with respect to enhancing business functions, may be found under the financial sections of this Report.

Strong business oriented and management processes would relieve the Dean of sufficient administrative encumbrance, so as to augment the Dean's contribution to academic leadership. Regardless of the dimensions and competencies of model academic leadership discussed in Section 9.1, leadership takes time. Too much operational management and there is too little time to devote to academic leadership.

7.2.4 Clinical Services

Recognizing the significant service delivery role of the COM, then incorporating a structural commitment to the management of this in the form of Associate Dean of Clinical Services, will go some ways towards improving the relationships with Saskatoon Health District and the other Health Districts. The clinical leader chosen for the Associate Dean of Clinical Services must be highly respected and known for consensus building, problem-solving, and a positive physician attitude. It is critically important that this individual have the full support of the Health Districts, the faculty and, indeed, the practising community. Such combination of attributes will not be found easily but are, nonetheless, necessary. It only makes sense, therefore, that the process for searching for and selecting this individual should take into account the input of these critically important stakeholders. From an organizational and structural perspective, this is one of the most urgent needs that the COM has. The absence of such a position has led to many of the misunderstandings and failings in the respective relationships. This is the person that must make the alignment of goals and objectives happen between the COM and Saskatoon Health District.

7.2.5 Clinical Services Fund

The CSF, described in more detail in 7.4.2.2, was originally developed as a thoughtful, strategic instrument for underwriting the cost of faculty resources, in lieu of fee-for-service income. Currently, the CSF is being used for far too many purposes and has become the only flexible source of funds in the face of what appears to be off-loading of costs and lessening of support from the UofS and, at times, Saskatoon Health District. Nonetheless, unilateral and singular control of this fund by the Dean's office, is not consistent with the strategic function that this

fund must play. Within the Dean's office, the fund must be much more closely managed through direct and meaningful meetings with Saskatchewan Health. Saskatchewan Health should have a single key designate for interacting with the COM. Operational and management issues should be dealt with at this level. From a strategic perspective, the CSF should be overseen by the University governance process, which will be discussed elsewhere. This should involve the Dean, but not exclusive to other key stakeholders.

Management of the CSF, with all of its strategic importance, must be well understood by those who are reimbursed from it. Transparent decision-making processes for resource allocations, clarification of purposes for the CSF and who is paid from it are necessary ingredients to improving understanding and accountability. Accordingly, there should be a thorough review of all aspects of expenditures and uses of the CSF, with a clear understanding documented in the CSF agreement between the UofS and Saskatchewan Health. We would reiterate, while the Dean must maintain the principal role in the management of the CSF, that this should not be exclusive of the governance body for the COM.

Recommendation:

We recommend that there be thorough review of the Clinical Services Fund, including all aspects of expenditures and uses of the Fund, with ultimately a clearly documented and renewed understanding in the form of a Clinical Services Fund Agreement between the University of Saskatchewan and Saskatchewan Health.

7.3 Academic Renewal

7.3.1 Undergraduate Medical Education

While this Review is not intended to examine undergraduate medical education specifically, including curricular content and educational processes, it is notable that concern exists regarding the relevance of UGME and the preparedness of the trainees to subsequently engage in non-urban practice. Notwithstanding these concerns, several successful programs have been implemented which appear to be strengthening the undergraduate educational process, as well as improving the potential for recruitment of new graduates. Having medical students receive experience in rural settings is critical to their development. To have such a program exist between their second and third years of undergraduate education is seen to be successful by both Health Districts and students. This program must be continued. In fact, there is a substantial argument for generalizing it, as we have suggested elsewhere. This could involve having students offered summer experiences between first and second year, with joint assignments to clinical and administrative leaders.

In the senior years, junior student interns (JURSI) spend clinical rotations in Regina. While these rotations are considered educationally valuable, some JURSI have been unhappy moving to Regina, unless they have family or acquaintances there. While there have been practical difficulties with JURSI relocating to Regina, these experiences should be encouraged and incorporated as a continuing feature within the final-year curriculum.

Recommendation:

We recommend that the junior rotating student interns continue to undertake clinical rotations in Regina, as a means of gaining additional clinical experience in the final-year curriculum.

7.3.2 Postgraduate Medical Education

There are dichotomous views regarding the ideal number and scope of PGME programs offered by the COM. On the one hand there is a perspective that further reductions in the number of programs will fundamentally threaten the COM, whereas the alternate view holds that the COM has far too diffuse an interest in postgraduate medical education and would benefit from greater focus. This, of course, should turn on the Vision and Mission of the COM. This matter is particularly important in light of recent RCPSC accreditation processes, which have resulted in four programs being placed on provisional approval and an additional two (anatomic and general pathology) assessed with the intent to discontinue. Internally within the COM and Pathology, it is assumed that Anatomic Pathology can be discontinued as a training program, provided that its resources are otherwise reallocated to General Pathology, a program which must continue as a central feature of the COM, and is needed to support a wide-range of surgical programs.

Organizationally, PGME programs are managed by the newly appointed part-time Associate Dean, who has done an excellent job of organizing committee structures, and attempting to improve training. As we have argued elsewhere, we believe that there should be a full-time Associate Dean of Education, with a reporting Assistant Dean of Postgraduate Medical Education (0.5FTE).

During the interview process, in relation to PGME programs, there was substantial reference to the previous strike in 1995 by interns and residents. The strike caused considerable consternation and, no doubt, impacted the desire of trainees to stay in Saskatchewan, upon completion. The reviewers were reassured by representatives of PGME trainees that much of the concern and ill-will associated with the previous strike had been resolved. This has been in part attributable to the recent decision of the UofS to forego tuition charges to interns and residents.

The current state of goodwill should not be taken for granted. It is incumbent upon the Dean's Executive to ensure that PGME trainees are actively involved in both planning and organization of their training, and that their feedback and input is both solicited and incorporated into strategic thinking.

7.3.3 Faculty Manpower and Resources

As we have discussed in 6.1.4, the Faculty Establishment, designated by each Department, initially appears to be a very thorough approach to intra-departmental manpower planning. On closer examination, it appears that for most departments, the faculty have not been meaningfully involved and, in some cases, these documents have been the exclusive purview of the Academic Head. As we have pointed out, there has never been a COM-wide manpower

planning process that has attempted to integrate the Faculty Establishment of each department. Worse still, the COM's manpower plan is not necessarily "in synch" with larger manpower plans at the provincial level. Of course, the absence of a comprehensive provincial manpower plan leaves the COM in an awkward position in which expectations are not clarified and success is not defined. Not surprisingly, yet regrettably, there is a widely-held view that the COM is often not a team player with respect to physician manpower planning. We reinforce and repeat our stated opinion that the COM must be a key stakeholder, but is not the mutually exclusive "owner" of physician manpower planning, which should continue from the substantial progress already made, as documented in the November 1997 Report of the Medical Council's Working Group on Physician Need.

Regardless of a physician manpower planning process for the Province, it is apparent that the critical mass of certain physician resources is inadequate and has resulted in consternation and disruptiveness. There is little question that the neurosurgical staff felt that failure to maintain critical mass of neurosurgeons was a central feature in the difficulty that led to the complex discussions which resulted in changes to neurosurgical reimbursement. In fact, the same holds true for many departments who have complained about progressive increases in workload, in relationship to reimbursement. A notable example is Diagnostic Imaging. The number of imaging procedures has progressively increased as the case mix and severity of patients attending Royal University Hospital has changed. In the face of constrained incomes and increasing workloads distributed amongst fewer radiologists, there has been both concern and service impacts, a prominent example being the controversy surrounding the management of the waiting times and scheduling for magnetic resonance imaging.

There are no magic bullets for dealing with faculty manpower and resource issues, other than an effective recruitment and retention process. However, as we have argued elsewhere, the search and selection mechanisms used to choose academic faculty and their leadership must include a wider input of key stakeholders who are affected by changes in faculty resources.

7.3.4 Graduate Studies

As a direct extension of the role of the Association Dean, Research, graduate training programs should be further developed in conjunction with the Faculty of Graduate Studies. We would advise that a Graduate Training Committee of the COM, responsible to the Faculty of Graduate Studies, be established to set policies and standards for development of graduate studies in the COM, and to review and approve admissions to graduate studies, and research proposals and programs for dissertation. Graduate students do impact on the workload of basic science and clinical faculty. Correspondingly, they can extend the academic productivity and publication output of faculty, if they are meaningfully incorporated within the larger research agenda of the COM, and are appropriately supervised in the conduct of their research. While this is an educational function, we would argue that it is best aligned to the Associate Dean, Research, given that unlike PGME programs, there is no clinical service component to the education and supervision, and graduate students are meant to engage in research as a central component of degree completion.

Recommendation:

We recommend that the College of Medicine establish a Graduate Training Committee responsible to the College of Medicine and Faculty of Graduate Studies, to set policies and standards for the development of graduate studies within the College of Medicine. This would include, but not be limited to, review and approval of admissions to graduate studies and review of research proposals and programs for dissertation. The Graduate Training Office for the College of Medicine should be established in alignment with the office of the Associate Dean Research.

7.4 FUNDING

7.4.1 Financial Analysis: Overview and Methodology

7.4.1.1 College Profile

In 1997, the COM had the following profile in terms of departments, students and staff:

- **18 Departments:**

Anaesthesia	Ophthalmology
Anatomy	Pathology
Biochemistry	Pediatrics
Community Health & Epidemiology	Pharmacology
Family Medicine	Physical Medicine and Rehabilitation
Medical Imaging	Physical Therapy
Medicine	Physiology
Microbiology	Psychiatry
Obstetrics & Gynecology	Surgery

- **639 Students:**

UGME (MD)	221
PGME	211
Graduate Students (MSc, PhD)	117
Physical Therapists	<u>90</u>
Total students	<u>639</u>

The intake demographics of undergraduate students are as follows:

In each of 4 years

• # from Saskatchewan	50
• # from other provinces	5

Of the total intake for each year, 3 are Aboriginal access, and the gender distribution is about 50% for each of male and females.

- **865 faculty**

Full-time:	
Tenured	151
Without Term	<u>94</u>
Subtotal - full time	<u>245</u>
Part-time	<u>620</u>
Total faculty	<u>865</u>

- **197 support and technical staff**

7.4.1.2 Methodology - Financial Statement Preparation and Analysis

The COM is one of a number of Colleges under the governance of the UofS Board of Governors. As such, the COM is not a separately governed entity with its own published audited financial statements.

In order to establish the credibility of the financial analysis, it was necessary to anchor the figures to the audited financial statements of the UofS. The following has therefore been done to accommodate this project:

- For the fiscal year ended April 30, 1998, and for the comparative year ended April 30, 1997, a Statement of Operations and Fund Balances for the COM "segment" of the audited financial statements of the UofS was prepared.
- The COM financial statements were prepared based on the same accounting policies and Funds as the UofS, and the same reporting format.

We acknowledge the significant effort that was made by the University and COM finance and administrative staff to prepare the financial statements of the COM in a format consistent with the financial statements of the University. We believe that this was a very worthwhile investment as it now provides a reliable basis for the analysis, and also provides the framework for future financial reporting.

The methodology for the financial analysis consists of the following:

- i) The seven Funds of the COM were identified, and a definition of the nature of operations of each Fund was obtained.
- ii) A Statement of Operations and Fund Balance for the COM was prepared for the fiscal years ending April 30, 1997 and 1998, with an audit trail to the UofS audited financial statements. A Statement of Operations and Fund Balances for the COM was also prepared for the 1998/99 Budget and the 1999/00 Forecast.
- iii) Significant changes in Revenue, Expenditure and Fund Balances between each of the years were queried, and explanations were obtained from COM staff. These explanations have not been verified in any manner by the reviewers, but rather have been received as information.
- iv) A detailed salary spreadsheet was prepared for each of the 1996/97 and 1997/98 fiscal year actual results, the 1998/99 Budget, and the 1999/00 Forecast. The purpose of these spreadsheets is to provide the distribution of total faculty salaries within the COM by Department by Fund, and within each Fund, the academic and service payment components.
- v) Sample copies of agreements were obtained for each type of staff (ie. full-time tenured, full-time without term, and part-time), to determine whether it would be possible to prepare a salary spreadsheet based on the percentage of time per the incumbent's contract distributed to academic and service components. The agreements are

generally silent on the expected distribution between these activities, and so this analysis was not possible.

- vi) The method of allocating faculty compensation to the academic and service components was determined. For faculty paid through Funds other than the Operating Fund, the academic component is calculated as if the collective agreement had been applied, with the clinical service component being the balance of the compensation.

7.4.1.3 Financial Overview

The Statement of Operations and Fund Balances for each of the fiscal years ending April 30 for 1997 through 2000 are provided in Appendix 1. For the most recent fiscal year ending April 30, 1998, the following Table highlights the total revenue, expenditures, net revenue (expenses) and Fund balance at the end of the year for each of the COM's seven Funds (in 000's):

Fund	% Of Total	Total Revenue	Total Expenditure	Net Revenue (Expenses)	Fund Balance, End of Year
Operating	21.7	\$15,411	\$15,344	\$67	\$1,377
Clinical Services	24.6	17,535	15,662	1,873	294
Clinical Practice Plan	20.4	14,511	16,975	(2,464)	(285)
Other Specific Purpose	13.9	9,904	9,124	780	8,824
Trust	4.1	2,906	654	2,252	4,374
Research	15.2	10,787	10,755	32	6,611
Endowment	0.1	117	0	117	7,041
Total	100	\$71,171	\$68,514	\$2,657	\$28,236

For the fiscal year ended April 30, 1998, the COM reported total revenue of \$71.2 million, total expenditures of \$68.5 million, for net revenue of \$2.7 million and a total Fund balance of about \$28.2 million. Of the total Fund balance of \$28.2 million, about \$26.8 million (95%) is in Other Specific Purpose, Trust, Research and Endowment Funds. Similarly, of the total net revenue of \$2.7 million, these four Funds generated a net revenue of \$3.2 million, while the Operating, Clinical Services, and Clinical Practice Plan Funds generated a combined net loss of about \$0.5 million.

Section 7.4.2 explores in more detail each of the seven Funds, providing a description of the nature of operations for each Fund and a four-year perspective, with an explanation of the revenue, expenditure, and Fund balance. Appendix 1 (a) through (d) provides this information by year.

7.4.2 Statement of Operations and Fund Balances

7.4.2.1 Operating Fund

a) Nature of Operations

The Operating Fund contains the revenue provided by the University from its General Operating Fund, and the corresponding expenditures incurred by the COM in support to its University academic programs.

b) Financial Analysis - Four Year Perspective - 1996/97 to 1999/00

The following explanatory notes are cross-referenced to the appropriate revenue, expenditure, and fund balance line items of the Operating Fund in Table 7.4.2.1.

Ref.	Explanation
	Revenue:
(1)	University Operating Budget - is the annual allocation from the University from all of its available sources of revenue (including grants from the Department of Post-Secondary Education, tuition, and other revenue) to the COM. This funding is to cover full-time tenured or tenure track employees, their support staff, and base operations for academic services. Percentage changes from one year to the next are typically applied on a uniform basis to all Colleges within the University, with some exception.
(2)	Student Fees - are centrally administered and form part of the University Operating Budget allocation as described in (1) above. For information purposes, 1998/99 regular session tuition and fees per undergraduate student amount to \$5,825, comprised of \$5,704 for tuition and \$121 for various fees.
	Expenditures:
(3)	Academic Staff Salaries - expenditures for full-time tenured or tenure-track academic employees. The footnote at the bottom of Table 7.4.2.1 provides the distribution between academic and clinical services expenditures. An analysis of faculty salaries by department by Fund is provided in Appendix 2 for each of the four years.
(4)	Other Salaries - expenditures for support staff within the offices of the academic staff and for COM administration.
(5)	Non-Salary - operational supplies, curriculum, and equipment rental and maintenance.
(6)	Fund Balances, end of year - the University implemented in 1984-85, a general operating budget program approved by the Board of Governors which allows budget units to carry forward unexpended funds into the subsequent fiscal year. The Fund balance, end of year of the Operating Fund is \$1,376,854, which is comprised of \$1,162,633 for general contingency of the COM, and \$214,221 for Medical Research Council contingency. Medical Research Council funds are not controlled by the COM, its departments nor the University. Only part of the operating general contingency is controlled and administered by the Dean of Medicine.

OPERATING FUND - 1996/97 to 1999/00 (in thousands)

Unaudited

Table 7.4.2.1

	Ref.	Actual 1997	% Change	Actual 1998	% Change	Forecast 1999	% Change	Forecast 2000
Revenues								
University operating budget	(1)	14,960	3.0%	15,411	6.2%	16,371	2.0%	16,699
Government grants and contracts								
Government of Canada								
Province of Saskatchewan								
Other								
Student Fees	(2)							
Gifts, grants and bequests								
Sales of services and products		53						
Income from investments								
Miscellaneous income								
		15,013	2.7%	15,411	6.2%	16,371	2.0%	16,699
Expenses								
Salaries								
Academic (see footnote below)	(3)	9,992	4.8%	10,472	7.5%	11,262	2.0%	11,487
Other	(4)	2,348	2.0%	2,394	2.5%	2,453	2.0%	2,502
Employee Benefits		1,547	-3.6%	1,491	24.1%	1,850	2.0%	1,887
Salaries and benefits		13,887	3.4%	14,357	8.4%	15,565	2.0%	15,876
Non - salary expenses	(5)	1,025	-3.7%	937	-18.3%	806	2.1%	823
		14,912	2.9%	15,344	6.7%	16,371	2.0%	16,699
Net revenues (expenses)		101		67		0		0
Interfund transfers				(17)				
Contingency account adjustments		76		175				
Net increase (decrease) in fund balances		177		225		0		0
Fund balances, beginning of year		975		1,152		1,377		1,377
Fund balances, end of year	(6)	1,152		1,377		1,377		1,377

Footnote:

Academic Staff Salaries Analysis:	(3)							
Academic		9,875		10,352		11,153		11,379
Clinical Services		117		120		109		102
Total per above Statement		9,992		10,472		11,262		11,487

7.4.2.2 Clinical Services Fund

a) Nature of Operations

The Clinical Services Fund (CSF) began in 1979, and contains the annual grant provided by Saskatchewan Health and related expenditures in accordance with a service agreement between the University and Saskatchewan Health

b) Financial Analysis - Four Year Perspective - 1996/97 to 1999/00

The following explanatory notes are cross-referenced to the appropriate revenue, expenditure, and fund balance line items of the CSF in Table 7.4.2.2:

Ref.	Explanation
	Revenue:
(2)	Province of Saskatchewan - funding for the provision of certain clinical, teaching, and research services. The annual revenue for the 1997, 1998 and 1999 fiscal years are consistent with funding letters from the Department of Health, adjusted for different year ends (Health - March 31, University - April 30). The revenue forecast for 2000 is based on the request made by the COM to enhance its programs and to provide for increases in compensation expenditures.
(3)	Sales of Services and Products - is the recovery of billings from Medical Imaging and the Alvin Buckwold Centre. These are non-billing groups supported by the CSF, and so a portion of any billing that does occur results in a reimbursement to the CSF.
	Expenditures:
(4)	Academic Staff Salaries - expenditures for: • Clinical services provided during the course of delivering academic programs that are not otherwise funded by fee-for-service revenue; • Certain academic services not supported by the Operating Fund. • Certain payments to private practitioners that teach on a part-time contractual basis for the COM.
	The footnote at the bottom of Table 7.4.2.2 provides the distribution between academic and clinical services expenditures. An analysis of faculty salaries by department by Fund within the COM is provided in Appendix 2 for each of the four years.
(5)	Other Salaries - expenditures to residents in PGME programs of the RCPSC and the CCFP. Also includes some support staff and COM administration salaries.
(6)	Inter-Fund Transfers - are transfers of funds to the CPP.
(7)	Fund Balances, end of year - is the accumulated excess (deficiency) of revenue over expenses. The accumulated deficit of \$910,000 at April 30, 1999 is caused by unfunded program and compensation changes in 1998 and 1999.

CLINICAL SERVICES FUND - 1996/97 to 1999/00 (in thousands)
Unaudited

Table 7.4.2.2

	Ref.	Actual 1997	% Change	Actual 1998	% Change	Forecast 1999	% Change	Forecast 2000
Revenues								
University operating budget								
Government grants and contracts								
Government of Canada								
Province of Saskatchewan	(1)	16,104	8.2%	17,432	5.5%	18,386	24.8%	22,951
Other								
Student Fees								
Gifts, grants and bequests								
Sales of services and products	(2)	124	-16.9%	103				
Income from Investments								
Miscellaneous Income								
		16,228	8.1%	17,535	4.9%	18,386	24.8%	22,951
Expenses								
Salaries								
Academic (see footnote below)	(3)	4,468	24.8%	5,578	4.6%	5,836	26.2%	7,363
Other	(4)	7,633	1.0%	7,713	11.4%	8,589	21.8%	10,461
Employee Benefits		918	-1.5%	904	10.2%	996	5.4%	1,050
Salaries and benefits		13,019	9.0%	14,195	8.6%	15,421	22.4%	18,874
Non - salary expenses		(38)		1,467	-38.9%	896	12.5%	1,008
		12,981	20.7%	15,662	4.2%	16,317	21.8%	19,882
Net revenues (expenses)		3,247		1,873		2,069		3,069
Interfund transfers	(5)	(2,572)		(2,635)		(3,273)		(3,069)
Contingency account adjustments								
Net increase (decrease) in fund balances		575		(762)		(1,204)		0
Fund balances, beginning of year		481		1,056		294		(910)
Fund balances, end of year	(6)	1,056		294		(910)		(910)

Footnote:

Academic Staff Salaries Analysis:	(3)				
Academic		1,802	1,818	2,121	2,208
Clinical Services		2,666	3,760	3,715	5,155
Total per above Statement		4,468	5,578	5,836	7,363

c) Historical Perspective

Table 7.4.2.2.1 provides a graphical overview of revenue and expenditures of the CSF, from the time of its origin in 1979 to the year 1999/00. Funding in 1979 was about \$4 million, which grew to \$11 million by 1986, where it held steady until 1989 before increasing rapidly to \$15 million in 1992 where it remained until 1996. During the years 1997 to 1999, actual funding has increased by 15.5%, while expenditures have increased by 24.2% during this period, fueled mainly by salary increases for faculty. The COM is budgeting for revenue and expenditures of about \$23 million in 1990/00, which if approved, would be a single year increase in expenditures of about 17.2% over the prior year.

A summary of funding changes is updated annually by the COM staff.

d) Changes in Clinical Services Fund Expenditures - 1996/97 to 1999/00

Table 7.4.2.2.2 focuses on the projected growth in expenditures within the CSF, between 1996/97 to 1999/00. During this three year period, expenditures including transfers to the CPP, increased by about 40% (from \$16.4 million to about \$23.0 million, an increase of about \$6.6 million).

In the Table, expenditure changes are classified into five categories with explanations provided. The changes are summarized as follows:

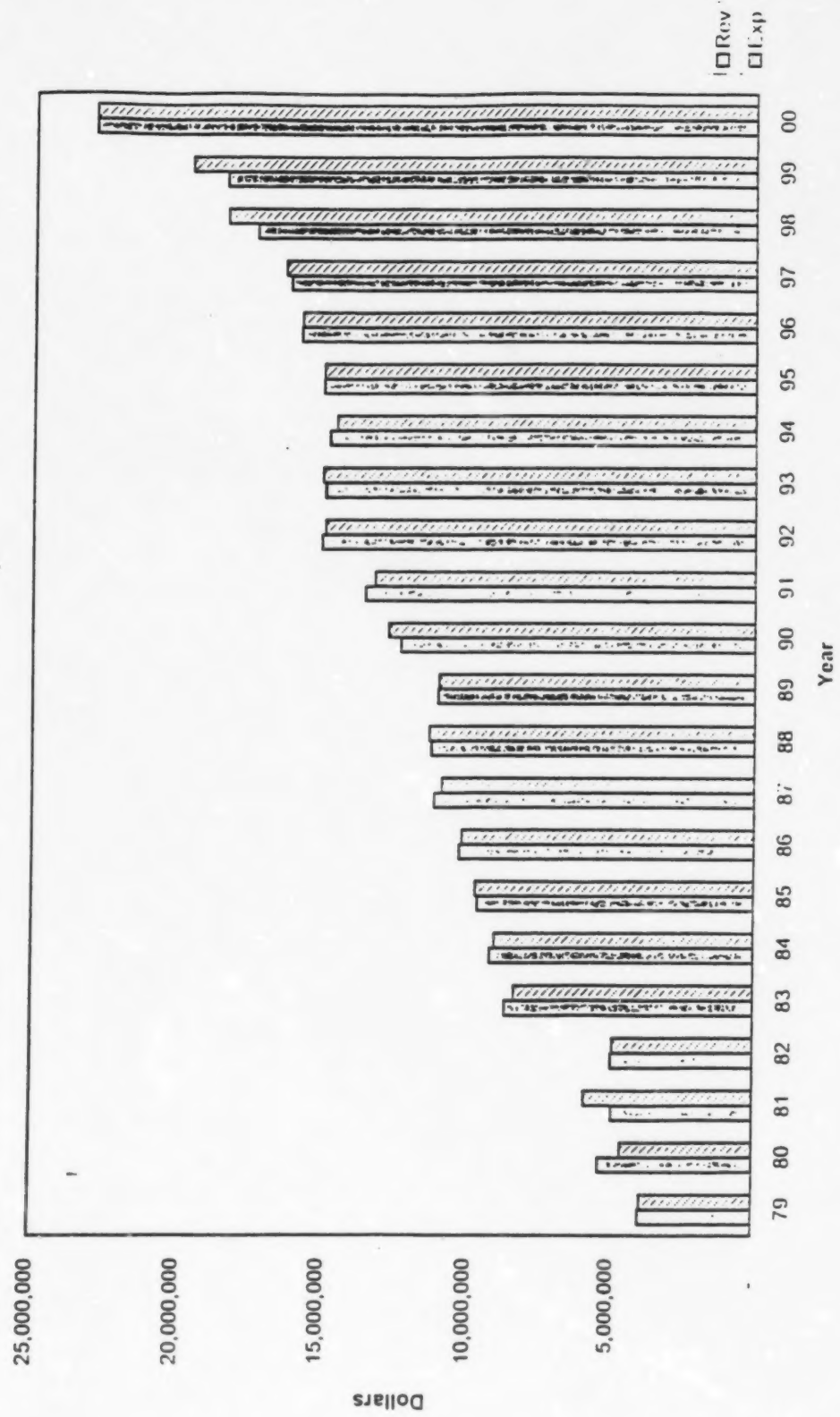
Type of Change	Amount	% of Total
Salary or inflation increases	\$5,138,926	77.8%
Program enhancements	1,822,749	27.6%
One time adjustments (net=0)		
Transfers to Saskatoon Health District	(510,000)	(7.7)%
Other adjustments	152,845	2.3%
Total net expenditure increase - 96/97 to 99/00	\$6,604,520	100.0%

e) Analysis of Salary or Inflation Increases - 1996/97 to 1999/00

Table 7.4.2.2.3 drills down into the increase in salary/inflation figure of \$5,138,926 identified in the table above, and provides the next layer of detail. The compensation of faculty is further addressed in Section 7.5.

Table 7 4 2 2 1

Clinical Services Fund



College of Medicine
Analysis of Changes in Clinical Services Fund Expenditures
Between 1996/97 and 1999/00

Table 7.4.2.2.2

Department or Object of Expenditure	Explanation	Classification of Changes					Total Changes	Actual 1997 & 98 Projected 1999 & 00 Expenditures
		Salary or Inflation Increase (note 1)	Program Enhancements	One Time Adjustments	Transfers to Sask Health Dist	Other Adjustments		
Actual 96/97 (y/e - March)								
Medical Imaging	Salary increase to radiologists	182,379					182,379	
Faculty salaries	Salary increases to Surgeons & Ophthalmology	846,827					846,827	
Faculty salaries	Retrospective pay increase (academic components)	111,675					111,675	
PT teaching	Increase in PT teaching activity (anomaly in 1997/98)		38,896	192,647			231,543	
PG&H	Retrospective pay increase	168,444					168,444	
	Other smaller changes							
Comm. medicine	Community based medicine program (one-time expenditure)			200,000		70,517	270,517	
Actual 97/98 (y/e - March)								
Faculty salaries	Salary increases to Fam. Med., O&G, Medicine, & Neonatology	918,495					918,495	
Medical Imaging	Additional positions (2)		440,000				440,000	
Nuclear Medicine	Transfer of salaries to Saskatchewan District Health				(142,442)		(142,442)	
PT teaching	Decrease in PT teaching activity (anomaly in 1997/98)			(192,647)			(192,647)	
PG&H	Increase in salaries & benefits re. new collective agreement	451,914					451,914	
	Other smaller changes							
Comm. medicine	Community based medicine program (one-time expenditure)			(200,000)		(51,182)	(251,182)	
Projected 98/99 (y/e - April)								
Faculty salaries	Salary increases to Family Medicine, Pediatrics, Psychiatry, Physical Med. & Rehab., CH&E, Pathology, & Microbiology	1,154,534					1,154,534	
Medical Imaging	Salary increases	1,019,191					1,019,191	
Family Medicine	Additional positions (2) plus one-time costs		278,679				278,679	
PG&H	Additional positions (11)		664,319				664,319	
Nuclear Medicine	Transfer of salaries to Saskatchewan District Health				(467,558)		(467,558)	
Alts in Buckworld	Fully funded position		112,298				112,298	
Medicine	Fully funded position		104,864				104,864	
Anaesthesia	Additional positions (2)		92,196				92,196	
CH&E	Transfer of salaries and expenses of practice to CH		91,480				91,480	
FM ID, Pharm, O&G	Inflationary changes	75,465					75,465	
	Other smaller changes					115,510	115,510	
Projected 99/00 (y/e - April)								
Total changes - 97 to 99/00		518,926	1,822,149		(510,000)	152,845	6,601,530	
% of total changes		7.8%	27.6%		7.9%	2.3%	100.0%	

Note 1 - see Table 7.4.2.3 for analysis of the column - salary or inflation increase

College of Medicine
Analysis of Salary or Inflation Increases
1996/97 to 1999/00

Table 7.4.2.2.3

Description	Annual Total (May to April)	# Staff	Average Increase/staff	Implementation Date
General Surgery	495,000	9	55,000	1-May-97
Orthopedic Surgery	350,000	5	70,000	1-May-97
Ophthalmology	150,000	3	50,000	1-May-97
1997/98 implementation	995,000			
Medicine	345,000	34.5	10,000	1-May-98
Medicine - Clinical Practice Plan subsidy	510,000	34.5	14,783	1-May-98
Obstetrics & Gynaecology	100,000	5	20,000	1-May-98
Family Medicine	50,000	10	5,000	1-May-98
1998/99 implementation	1,005,000			
Family Medicine	50,000	10	5,000	1-May-99
Psychiatry	438,000	12	36,500	1-May-99
Pediatrics	471,534	21	22,454	1-May-99
Pathology	70,000	14	5,000	1-May-99
Community Health & Epid	20,000	2	10,000	1-May-99
Microbiology	20,000	4	5,000	1-May-99
Physical Medicine & Rehab	80,000	4	20,000	1-May-99
1999/00 implementation	1,149,534			
Subtotal - Departmental increases	3,149,534			
Adjust to align with actuals in Table 7.4.2.2.2	(219,576)			
Subtotal	2,929,856			
Radiologists - 96/97	182,379			
Academic services - salary increase	111,675			
Post graduate medical education - 96/97	368,444			
Post graduate medical education - 97/98	451,914			
Medical Imaging - 99/00 -	1,019,193			
Family Medicine, Infectious Diseases, Pharmacology, O & G - inflation	75,465			
Total salary or inflation increases per Table 7.4.2.2.2 - 1996/97 to 1999/00	5,138,926			

f) Explanation of Annual Operating Deficits

Table 7.4.2.2.4 provides an explanation of factors that have contributed to the growth of the annual deficit of the CSF between 1996/97 and 1998/99. For the year ended March 31, 1997 (Saskatchewan Health's year-end), the deficit was \$184,341. The deficit for the 1997/98 year grew to just slightly over \$1 million, and in the current year is projected to be \$1.2 million. The growth in the deficit is tracked as the difference between revenue and expenditures for each of the factors identified in the Table.

g) Funding Request of the College of Medicine

The 1999/00 forecast on the financial statement of the CSF (Table 7.4.2.2) indicates a request that funding be increased from the 1998/99 level of \$18.4 million to about \$23.0 million, an increase of \$4.6 million to achieve a balanced budget for the 1999/00 fiscal year. The funding request is in regards to the following:

Existing shortfall in base funding - see Table 7.4.2.2.4	<u>\$1,203,826</u>
Proposed new spending - 1999/00:	
Salary increases to Family Medicine, Pediatrics, Psychiatry, Physical Medicine & Rehabilitation, Community Health & Epidemiology, Pathology, and Microbiology	1,154,534
Medical Imaging - salary increase	1,019,193
Supply cost increases	75,465
Family Medicine - 2 additional positions + one time costs	278,679
Postgraduate Medical Education - 13 additional positions	664,339
Alvin Buckwold Centre - fully funded position	112,298
Medicine - fully funded position	104,861
Anaesthesia - 2 additional positions	92,196
Community Health & Epidemiology	91,480
Other	<u>135,510</u>
Subtotal - proposed new spending	<u>3,728,555</u>
Transfer of Nuclear Medicine to Saskatoon Health District	<u>(367,558)</u>
Net funding increase requested by the College of Medicine	<u>\$4,564,823</u>

Compensation of faculty in comparison to private practice is analyzed in Section 7.5. The other program enhancement requests have not been analyzed.

Clinical Services Fund
Explanation of Annual Operating Deficits
1996/97 to 1998/99

Table 7.4.2.2.4

Department or Object of Expenditure	Explanation	Revenue	Expenditures	Changes to Annual Surplus (Deficit)
Actual 96/97 - March yearend				
Medical Imaging	Salary increase to radiologists	16,162,560	16,346,901	(184,341)
Faculty salaries	Salary increases to Surgery & Ophthalmology		182,379	(182,379)
Faculty salaries	Retroactive pay increase (academic components)	1,000,000	836,827	163,173
PT teaching	Increase in PT teaching activity (anomaly in 1997/98)		111,675	(111,675)
PGME	Retroactive pay increase		231,543	(231,543)
Comm. medicine	*Other smaller changes	188,000	368,444	(180,444)
	Community based medicine program (one-time expenditure)	(9,050)	70,517	(79,567)
			200,000	(200,000)
Actual 97/98 March yearend				
Faculty salaries	Salary increases to Fam. Med., O&G, Medicine, & Neonatology	17,341,510	18,348,286	(1,006,776)
Medical Imaging	Additional positions (2)	1,000,000	938,495	61,505
Nuclear Medicine	Transfer of salaries to Saskatoon District Health		440,000	(440,000)
PT teaching	Decrease in PT teaching activity (anomaly in 1997/98)	(142,442)	(142,442)	
PGME/Faculty	Increase in salaries & benefits re: new collective agreement	279,097	(192,647)	192,647
PGME	Increase in salaries & benefits re: new collective agreement		279,097	(279,097)
Comm. medicine	*Other smaller changes	(91,567)	451,914	(451,914)
	Community based medicine program (one-time expenditure)		(53,182)	(38,385)
			(200,000)	200,000
Projected - March/99 yearend	(Note: Revenue is confirmed by Sask Health)			
		18,386,598	19,590,424	(1,203,826)
Projected - April/99 yearend	Amounts per 1998/99 column of Table 7.4.2.2 **			
		18,386,598	19,590,424	(1,203,826)

*Decrease reflects lower fee-for-service billing recovery in 97/98 than 96/97 and in 98/99 than in 97/98.

** Expenditures are comprised of \$16,317,330 plus transfers to the CPP of \$3,273,094, for a total of \$19,590,424.

7.4.2.3 Clinical Practice Plan

a) Nature of Operations

The CPP applies to some of the clinical departments of the COM that require the professional practice of Medicine in the delivery of University academic and teaching programs and for research and scholarly work. A distinguishing feature of these clinical departments is that they generate revenue by providing medical services on a fee-for-service basis, most of which is billed to and collected from the Medical Services Plan of Saskatchewan Health. This fee-for-service revenue supports the clinical service component of faculty salaries, and also academic components that are not supported by either the Operating or CSF.

b) Financial Analysis - Four Year Perspective - 1996/97 to 1999/00

The following explanatory notes are cross-referenced to the appropriate revenue, expenditure, and fund balance line items of the CPP in Table 7.4.2.3:

Ref.	Explanation
	Revenue:
(1)	Sales of services and products - Is the category used to report fee-for-service revenue of the COM. Fee-for-service revenue was about \$12.957 million in 1997, increasing by 7.9% in 1998 to \$13.980 million. Revenue is forecasted to increase by 0.8% in 1999 (to \$14.095 million), and a further 2.0% in 2000 (to \$14.377 million), based on a full complement of faculty, and fee increases approved within the Medical Services Plan.
	Expenditures:
(2)	Academic Staff Salaries - expenditures for: • Clinical services provided during the course of delivering academic programs that generate fee-for-service revenue; • Certain academic services of full-time faculty not supported by the Operating or CSF; • Payment of the academic component of salary to "without-term" full-time faculty in the COM who are not supported by the Operating or CSF.

The footnote at the bottom of Table 7.4.2.3 provides the distribution between academic and clinical services expenditures. An analysis of faculty salaries by department by Fund within the COM is provided in Appendix 2 for each of the four years.

- (3) **Other Salaries** - expenditures for support staff within the offices of faculty.
- (4) **Inter-Fund Transfers** - are transfers from the CSF.
- (5) **Fund Balances, end of year** - Although the Fund balance is in a deficit in 1998 (\$285,000), the forecast indicates that the Fund should be in a surplus position of about \$127,000 by the end of 1999.

CLINICAL PRACTICE PLAN - 1996/97 to 1999/00 (in thousands)
Unaudited

Table 7.4.2.3

	Ref.	Actual 1997	% Change	Actual 1998	% Change	Forecast 1999	% Change	Forecast 2000
Revenues								
University operating budget								
Government grants and contracts								
Government of Canada								
Province of Saskatchewan		4	750.0%	34				
Other								
Student Fees								
Gifts, grants and bequests		97	412.4%	497				
Sales of services and products	(1)	12,957	7.9%	13,980	0.8%	14,095	2.0%	14,377
Income from Investments								
Miscellaneous Income								
		13,058	11.1%	14,511	-2.9%	14,095	2.0%	14,377
Expenses								
Salaries								
Academic (see footnote below)	(2)	8,062	8.3%	8,730	17.4%	10,251	2.0%	10,456
Other	(3)	2,786	16.1%	3,235	-17.8%	2,660	2.0%	2,714
Employee Benefits		866	-2.7%	843	22.3%	1,031	1.9%	1,051
Salaries and benefits		11,714	9.3%	12,808	8.9%	13,942	2.0%	14,221
Non - salary expenses		4,393	-5.1%	4,167	-30.5%	2,897	2.0%	2,955
		16,107	5.4%	16,975	-0.8%	16,839	2.0%	17,176
Net revenues (expenses)		(3,049)		(2,464)		(2,744)		(2,799)
Interfund transfers	(4)	2,556		2,519		3,156		2,952
Contingency account adjustments								
Net increase (decrease) in fund balances		(493)		55		412		153
Fund balances, beginning of year		153		(340)		(285)		127
Fund balances, end of year	(5)	(340)		(285)		127		280
Footnote:								
Academic Staff Salaries Analysis:	(2)							
Academic		1,267		1,415		1,735		1,688
Clinical Services		6,795		7,315		8,516		8,768
Total per above Statement		8,062		8,730		10,251		10,456

7.4.2.4 Other Specific Purpose Fund

a) Nature of Operations

The Other Specific Purpose Fund is used for a variety of programs that directly or indirectly support or complement the main teaching, research and service functions of the COM. For example, a major amount of the annual revenues and expenditures in this Fund is related to the operation of the Northern Medical Services Unit under the aegis of the Department of Family Medicine. All departments maintain accounts that are intended to support and enhance academic programs. The clinical departments maintain accounts that supplement their operations and are used in part to pay faculty salary supplements that pertain to the previous fiscal year. Some expenditures from this fund directly support research.

b) Financial Analysis - Four Year Perspective - 1996/97 to 1999/00

The following explanatory notes are cross-referenced to the appropriate revenue, expenditure, and fund balance line items of the Other Special Purpose fund in Table 7.4.2.4:

Ref.	Explanation
Revenue:	
(1)	Government of Canada - contract research and contractual services
(2)	Province of Saskatchewan - contract research and contractual services
(3)	Gifts, grants and bequests - contractual services - non-government
(4)	Sales of services and products - includes Continuing Medical Education courses and other services such as the Andrology Laboratory of the Department of Obstetrics and Gynecology or medico-legal autopsies in the Department of Pathology.
Expenditures:	
(5)	Academic Staff Salaries - expenditures for clinical or academic services provided for specific projects or purposes.
The footnote at the bottom of Table 7.4.2.4 provides the distribution between academic and clinical services expenditures. An analysis of faculty salaries by department by Fund within the COM is provided in Appendix 2 for each of the four years.	
(6)	Other Salaries - expenditures for support staff for contractual services.
(7)	Inter-Fund Transfers - are transfers from the CSF.
(8)	Fund Balances, end of year - this Fund is in an accumulated surplus position of \$8.824 million at the end of 1998, made up of 165 separate accounts with individual balances. Of the total Fund Balance, about \$1.9 million appears to be discretionary (ie. without specific terms). The majority of these accounts are administered by department heads and faculty.

OTHER SPECIAL PURPOSE FUND - 1996/97 to 1999/00 (in thousands)

Unaudited

Table 7.4.2.4

	Ref.	Actual 1997	% Change	Actual 1998	% Change	Forecast 1999	% Change	Forecast 2000
Revenues								
University operating budget								
Government grants and contracts								
Government of Canada	(1)	1,297	1.0%	1,310	0.0%	1,310	0.0%	1,310
Province of Saskatchewan	(2)	3,630	37.7%	4,997	0.0%	4,997	0.0%	4,997
Other		259	-50.6%	128	0.0%	128	0.0%	128
Student Fees								
Gifts, grants and bequests	(3)	1,723	38.9%	2,393	0.0%	2,393	0.0%	2,393
Sales of services and products	(4)	915	16.7%	1,068	0.0%	1,068	0.0%	1,068
Income from Investments				8	0.0%	8	0.0%	8
Miscellaneous Income								
		7,824	26.6%	9,904	0.0%	9,904	0.0%	9,904
Expenses								
Salaries								
Academic (see footnote below)	(5)	1,704	-11.9%	1,502	-26.8%	1,099	12.1%	1,232
Other	(6)	5,273	17.0%	6,167	0.0%	6,167	0.0%	6,167
Employee Benefits		475	20.4%	572	0.0%	572	0.0%	572
Salaries and benefits		7,452	10.6%	8,241	-4.9%	7,838	1.7%	7,971
Non - salary expenses		1,240	-28.9%	882	147.4%	2,182	-6.1%	2,049
		8,692	5.0%	9,123	9.8%	10,020	0.0%	10,020
Net revenues (expenses)		(868)		781		(116)		(116)
Interfund transfers	(7)	116		116		116		116
Contingency account adjustments								
Net increase (decrease) in fund balances		(752)		897		0		0
Fund balances, beginning of year		8,679		7,927		8,824		8,824
Fund balances, end of year	(8)	7,927		8,824		8,824		8,824
Footnote:								
Academic Staff Salaries Analysis:	(5)							
Academic		321		369		363		275
Clinical Services		1,383		1,133		736		957
Total per above Statement		1,704		1,502		1,099		1,232

7.4.2.5 Trust Fund

a) Nature of Operations

The Trust Fund contains accounts that are for a purpose specified by the person(s) or entity donating or contributing such funds to the University. These accounts usually earn income and expenditures are made based upon the written instructions of the donor or contributor, usually related to the support of students and/or faculty members for research and/or scholarly activity.

b) Financial Analysis - Four Year Perspective - 1996/97 to 1999/00

The following explanatory notes are cross-referenced to the appropriate revenue, expenditure, and fund balance line items of the Trust Fund in Table 7.4.2.5:

Ref.	Explanation
	Revenue:
(1)	Gifts, grants and bequests - is the amount of annual contributions from various donors.
(2)	Income from Investments - is the amount of investment income earned on all of the COM's Funds. In 1998, the University changed its accounting policy to record investments at market value, which explains the one time dramatic increase in investment revenue earned in 1998. Previously, investments were recorded at cost.
	Expenditures:
(3)	Non-Salary - expenditures for administrative fees and non-salary purchases made in accordance with the terms of the individual Trust account.
(4)	Inter-fund transfers - represents the capitalization of interest earned on Endowment Fund accounts, which is transferred to the Endowment Fund. Prior to 1998, this interest would have remained in the Trust Fund.
(5)	Fund Balances, end of year - this Fund is in an accumulated surplus position of \$4.374 million at the end of 1998, made up of 39 separate accounts with individual balances. All accounts have restrictions on the purpose of expenditure.

TRUST FUND - 1996/97 to 1999/00 (in thousands)
Unaudited

Table 7.4.2.5

Ref.	Actual 1997	% Change	Actual 1998	% Change	Forecast 1999	% Change	Forecast 2000
Revenues							
University operating budget							
Government grants and contracts							
Government of Canada							
Province of Saskatchewan							
Other							
Student Fees							
Gifts, grants and bequests	(1)	96	199.0%	287	0.0%	287	0.0%
Sales of services and products							
Income from investments	(2)	636	300.8%	2,549	-75.0%	636	0.0%
Miscellaneous income		99	-29.3%	70	0.0%	70	0.0%
		831	249.7%	2,906	-65.8%	993	0.0%
Expenses							
Salaries							
Academic (see footnote below)							
Other		1					
Employee Benefits							
Salaries and benefits		1					
Non - salary expenses	(3)	588	11.2%	654	0.0%	654	0.0%
		589	11.0%	654	0.0%	654	0.0%
Net revenues (expenses)		242	2,252		339		339
Interfund transfers	(4)	(80)	(2,977)				
Contingency account adjustments							
Net increase (decrease) in fund balances		162	(725)		339		339
Fund balances, beginning of year		4,937	5,099		4,374		4,713
Fund balances, end of year	(5)	5,099	4,374		4,713		5,052

7.4.2.6 Research Fund

a) Nature of Operations

Research accounts contain the revenues and expenditures in support of research projects carried out by full-time faculty members of the COM. There are both external and internal sources of funds for these projects, which generally require a peer review process prior to grant approval. Research contracts are also included in this Fund.

(b) Financial Analysis - Four Year Perspective - 1996/97 to 1999/00

The following explanatory notes are cross-referenced to the appropriate revenue, expenditure, and fund balance line items of the Research Fund in Table 7.4.2.6:

Ref.	Explanation
	Revenue:
(1)	Government of Canada - includes funding from the Medical Research Council of Canada, Health Canada and Natural Sciences and Engineering Research Council of Canada.
(2)	Province of Saskatchewan - funding from Saskatchewan Health, Saskatchewan Government Insurance, Health Services Utilization and Research Commission, Saskatchewan Agriculture and Saskatchewan Crop Development Board.
(3)	Gifts, grants and bequests - revenue from pharmaceutical companies and private donations.
	Expenditures:
(4)	Academic Staff Salaries - expenditures for clinical or academic services provided for specific research projects.
	The footnote at the bottom of Table 7.4.2.6 provides the distribution between academic and clinical services expenditures. An analysis of academic salaries by department by Fund within the COM is provided in Appendix 2 for each of the four years.
(5)	Other Salaries - expenditures for researchers, their assistants, and related support.
(6)	Non-Salary - expenditures for operational supplies and services in support of research.
(7)	Fund Balances, end of year - this Fund is in an accumulated surplus position of \$6.611 million at the end of 1998, and is forecasted to grow to about \$6.819 million by the end of 1999. There are 485 separate accounts with individual balances that make up the total Fund Balance of \$6.611 million in 1998. The Dean of Medicine generally cannot redirect the use of Research funds for any alternate purpose.

RESEARCH FUND - 1996/97 to 1999/00 (in thousands)
Unaudited

Table 7.4.2.6

	Ref.	Actual 1997	% Change	Actual 1998	% Change	Forecast 1999	% Change	Forecast 2000
Revenues								
University operating budget								
Government grants and contracts								
Government of Canada	(1)	2,738	-8.7%	2,500	0.0%	2,500	0.0%	2,500
Province of Saskatchewan	(2)	2,265	31.8%	2,986	0.0%	2,986	0.0%	2,986
Other		70	58.6%	111	0.0%	111	0.0%	111
Student Fees								
Gifts, grants and bequests	(3)	5,247	-2.0%	5,141	0.0%	5,141	0.0%	5,141
Sales of services and products		6	-50.0%	3	0.0%	3	0.0%	3
Income from investments								
Miscellaneous Income		12	283.3%	46	0.0%	46	0.0%	46
		10,338	4.3%	10,787	0.0%	10,787	0.0%	10,787
Expenses								
Salaries								
Academic (see footnote below)	(4)	194	88.7%	366	-48.1%	190	37.9%	252
Other	(5)	6,394	-4.7%	6,095	0.0%	6,095	0.0%	6,095
Employee Benefits		516	-5.0%	490	0.0%	490	0.0%	490
Salaries and benefits		7,104	-2.2%	6,951	-2.5%	6,775	1.1%	6,847
Non - salary expenses	(6)	2,988	27.3%	3,804	0.0%	3,804	0.0%	3,804
		10,092	6.6%	10,755	-1.6%	10,579	0.7%	10,651
Net revenues (expenses)		246		32		208		136
Interfund transfers								
Contingency account adjustments								
Net increase (decrease) in fund balances		246		32		208		136
Fund balances, beginning of year		6,333		6,579		6,611		6,819
Fund balances, end of year	(7)	6,579		6,611		6,819		6,955
Footnote:								
Academic Staff Salaries Analysis:	(4)							
Academic		194		219		148		219
Clinical Services				147		42		43
Total per above Statement		194		366		190		252

7.4.2.7 Endowment Fund

a) Nature of Operations

The Endowment Fund accounts for resources received with the stipulation that the original contribution not be spent. The Fund also consists of a portion of the investment income earned on these funds that is required by the donors and the Board of Governors to be added to the Fund to offset the eroding effect of inflation.

b) Financial Analysis - Four Year Perspective - 1996/97 to 1999/00

The following explanatory notes are cross-referenced to the appropriate revenue, expenditure, and fund balance line items of the Endowment Fund in table 7.4.2.7:

Ref.	Explanation
	Revenue:
(1)	Gifts, grants, and bequests - reflect annual endowment contributions.
(2)	Inter-fund transfers - represents the capitalization of interest earned on Endowment Fund accounts, which is transferred from the Trust Fund. Prior to 1998, this interest would have remained in the Trust Fund.
(3)	Fund Balances, end of year - this Fund is in an accumulated surplus position of \$7.041 million at the end of 1998, and is forecasted to grow to about \$7.158 million by the end of 1999. There are 56 separate accounts with individual balances that make up the total Fund Balance of \$7.041 million in 1998.

ENDOWMENT FUND - 1996/97 to 1999/00 (in thousands)

Unaudited

Table 7.4.2.7

	Ref.	Actual 1997	% Change	Actual 1998	% Change	Forecast 1999	% Change	Forecast 2000
Revenues								
University operating budget								
Government grants and contracts								
Government of Canada								
Province of Saskatchewan								
Other								
Student Fees								
Gifts, grants and bequests	(1)	95	23.2%	117	0.0%	117	0.0%	117
Sales of services and products								
Income from Investments								
Miscellaneous Income								
		95	23.2%	117	0.0%	117	0.0%	117
Expenses								
Salaries								
Academic (see footnote below)								
Other								
Employee Benefits								
Salaries and benefits								
Non - salary expenses								
Net revenues (expenses)		95		117		117		117
Interfund transfers	(2)	80		2,977				
Contingency account adjustments								
Net increase (decrease) in fund balances		175		3,094		117		117
Fund balances, beginning of year		3,772		3,947		7,041		7,158
Fund balances, end of year	(3)	3,947		7,041		7,158		7,275

7.4.3 Budget Process and Approval

The presentation of the annual Budget to the University Board of Governors for approval is limited to the Operating Fund, which is the same approach used for all Colleges within the University. The other six Funds of the COM are not a part of the Budget document, with the perspective being that such Funds are governed by the terms and conditions applied by other key stakeholders, as follows:

Fund	Key Stakeholder
CSF	Department of Health
CPP	Clinical departments and faculty
Other Specific Purpose	Various funding agencies
Trust	Trust terms and conditions
Research	Research terms and conditions
Endowment	Endowment terms and conditions

Although the CSF and CPP are not presented to the Board for approval, annual budgets are prepared by the COM staff for presentation to Saskatchewan Health and the Clinical departments, respectively. Budgets are not prepared for the Other Specific Purpose, Trust, Research and Endowment Funds, with the rationale being that the activity in these accounts fluctuate a great deal from year-to-year, and therefore, are not susceptible to forecasting. The Budgets that are used for these four Funds are simply the previous year's actual results which are provided as a benchmark.

To put this in perspective, of the total revenue of the COM of \$71.2 million in 1997/98, the following received various levels of approval (in thousands):

Fund	Approval Level	Total Revenue	% of Revenue
Operating	Board of Governors	\$15,411	21.7%
Clinical Services	Saskatchewan Health	17,535	24.6%
Clinical Practice Plan	Clinical Departments	14,511	20.4%
Subtotal	Budgets approved, but not at Board Level	32,046	45.0%
Other Specific Purpose		9,904	13.9%
Trust		2,906	4.1%
Research		10,787	15.2%
Endowment		117	0.1%
Subtotal	Budgets not prepared	23,714	33.3%
Total		\$71,171	100.0%

The above Table illustrates that the Board approves only 21.7% of the COM's total annual budget, while 45.0% is approved by other stakeholders, and 33.3% is not formally approved. For the 33.3% that is not budgeted, accountability is defined by the terms and conditions of the particular funds, with reporting generally required by the various contributors in regards to actual revenues, expenditures and closing balances, either on an annual basis, or after the project or activity is completed.

Another observation is that the UofS and, likewise, the COM do not prepare an operating plan for more than the upcoming year. One of the parameters of this Review was to prepare a forecast for the 1999/00 year, to help determine the effects of current operating decisions on subsequent years. In order for the COM to be proactive and anticipate change, it is necessary to look beyond the current year in its fiscal, physical, and human resources planning. Conventionally, this is done on a 3-5 year time horizon.

While it is understood that there are a number of checks and balances in the present budget preparation and approval process, there is nevertheless a level of accountability that needs to be exercised by the Board that includes a good understanding of all resources administered by the UofS. This accountability includes:

- Approval of the consolidated budget of the UofS, inclusive of all of the Funds of the COM.
- An understanding of the key projects and activities that are planned in regards to Other Specific Purpose, Trust, Research, and Endowment Funds. There are about 750 accounts within these Funds with designated signing authorities. It is unreasonable to present information on all these accounts to the Board, however, presenting a plan for the top 20 accounts (or other appropriate number), as measured by the account balance at the end of the previous year would give a good indication of the types of activities that will be undertaken, and also allow a year-end report to be presented on what was accomplished in relation to the plan.
- Approval of the annual audited consolidated financial statements, with the approved consolidated budget provided as a reference column in the Statement of Operations.
- Management discussion and analysis of the consolidated financial statements, explaining significant variances between actual results and the budget, and also from one year to the next.
- Approval of the annual report that includes the consolidated financial statements.
- Introducing a planning cycle that extends beyond the upcoming year to ensure that the future directions of the various Colleges and the University overall have a better opportunity to anticipate and adjust to change.

7.5 Compensation of Faculty

7.5.1 Overview - Perceptions and Historical Events

Table 7.4.2.2.3 provides an analysis of salary or inflation increases that have been implemented or are forecast to be implemented within the CSF, the annual total, the number of staff receiving the increases, and the average increase per faculty.

On May 1, 1997, the COM increased the salaries for the staff in the Departments of General Surgery, Orthopedic Surgery, and Ophthalmology. On May 1, 1998, salary increases were implemented for Medicine, Obstetrics and Gynecology and a partial increase was provided to Family Medicine.

Salary increases that are forecast to be implemented in 1999/00 are in Family Medicine (remaining balance), Psychiatry, Pediatrics, Pathology, Community Health and Epidemiology, Microbiology, and Physical Medicine and Rehabilitation.

The following is an account of the historical events as provided by the COM:

- The first adjustments made from the CSF were in the Department of Surgery, in the Divisions of General and Orthopedic Surgery. These adjustments occurred shortly after an agreement had been made between the UofS and Saskatchewan Health for the Division of Neurosurgery, Department of Surgery.
- The Neurosurgery agreement is effective for three years from May 1, 1997 to April 30, 2000. The changes were approved by Saskatchewan Health following consultation with others. Those consulted included, but were not limited to, UofS officials, Saskatoon Health District, and the SMA. The agreement is not directly linked with the CSF but it includes a commitment on the part of Saskatchewan Health to consider alternate payment matters for the other Divisions of the Department of Surgery.
- The agreement for members of the Division of Neurosurgery provided for an amount of \$70,000 per annum paid directly through the University payroll such that the average gross salary of \$180,000 per annum was increased to \$250,000 per annum, a 40% increase in personal income. The \$70,000 increase per member of the Division of Neurosurgery was intended to bypass the established routines of the Department of Surgery CPP, so that no departmental or College operating or enhancement fund deductions were made from this amount. This established full-time faculty gross salary amounts in the high percentiles related to private practice.
- The agreement for the Division of Neurosurgery set the stage for consideration of the members of the General and Orthopedic Divisions, who were allocated a similar percentage salary adjustment.
- For each of the General Surgeons the increase amounted to \$55,000 and for the Orthopedic Surgeons, \$70,000 per annum. Of the initial \$1,000,000 provided by Saskatchewan Health during 1997-98 for faculty salary enhancement, the allocations to the Divisions of General and Orthopedic Surgery consumed \$845,000 (annualized). Of

the remainder, \$150,000 was allocated at \$50,000 each to the three full-time faculty in the Department of Ophthalmology, again with retroactivity to May 1, 1997. The allocation in Ophthalmology was precipitated by the potential departure of one of the full-time faculty. The total salary enhancement implemented in 1997/98 amounted to \$995,000.

- The adjustments to salaries for Department of Surgery members took place in September and October, 1997 with retroactivity to May 1, 1997. The Dean of the COM immediately began internal proceedings to determine appropriate adjustments for other Departments of the COM. This process continued until the submission of the 1998-99 CSF budget in July, 1998 wherein a request was made that, if granted, would provide adjustments for all other departments. Department members were encouraged to consult with the SMA and members of the SMA's staff attended several meetings at the University.
- The CSF budget approval was adjusted by \$2,000,000 between the 1997-98 and 1998-99 fiscal years. This allowed an additional allocation of salary enhancement funds to the Departments of Medicine (\$855,000), Family Medicine (\$50,000) and Obstetrics and Gynecology (\$100,000) for a total of \$1,005,000 effective May 1, 1998.
- The data assembled in the COM, which included information about certain medical specialists payments from the Provincial Medical Services Plan (provided by Saskatchewan Health) were used in the determination of changes to clinical faculty members' salaries. This was supplemented by written or verbal submissions from Academic Heads and other Department members throughout the process.

The Human Resources Department of the University was not consulted during this process, as these adjustments are outside of the administration of the collective agreement.

The approach to applying salary adjustments appears to have been a cascade of events arising from the potential loss of Neurosurgical services. In hindsight, the time and effort should have been taken to obtain appropriate Human Resources expertise and advice, to set an overall compensation policy to ensure both internal and external equity, and achieve the long-term objective of recruiting and retaining highly qualified faculty. A compensation policy might have included the following:

- Salary set at a specified percentile relative to other medical schools in Canada, which are the main competitors and reference points for faculty (external equity).
- Salary set to specified index levels in relation to private practice incomes for each Department. The index levels may vary, depending on the specific circumstances of each Department (external equity).
- Salary set on a 'relative value' basis, which would establish compensation relative to performance in the areas of academic and clinical services, and research (internal equity).

7.5.2 Academic vs Private Practice Compensation

Appendix 3 compares estimated average private practice pre-tax income (net of estimated overhead and employer expenses) to full-time faculty average gross salary for the 1996/97 and 1997/98 fiscal years. The 1996/97 analysis (Appendix 3(a)) was used by COM staff as one source of information for determining the distribution of salary increases. This analysis was updated using 1997/98 data (Appendix 3(b)).

Table 7.5.2 summarizes the information contained in appendices 3(a) and 3(b). The highlights are as follows:

- Changes in estimated net pre-tax private practice incomes between 1996/97 and 1997/98 ranged from a decrease of (12.9)% in Respiriology to an increase of 13.3% in Dermatology.
- Changes in the average gross salary within the COM ranged from a decrease of (4.5)% in Neurology to an increase of 57.0% in General Surgery.
- The gap between private practice net pre-tax incomes and faculty salaries, as expressed by the indexes, narrowed for 15 of the 25 specialties or subspecialties listed in the Table. The most significant changes in the indexes occurred for those areas that received the salary enhancement in 1997/98 (Neurosurgery, General Surgery, Orthopedic Surgery, and Ophthalmology).
- In 1997/98, the comparative earnings relationship between private practice and faculty is:

Private Practice > Faculty Salaries	Private Practice < Faculty Salaries
Obstetrics & Gynecology	Anaesthesia
Ophthalmology	Family Medicine - metro
Psychiatry	General Pediatrics
Cardiology	Orthopedic Surgery
Endocrinology	General Surgery
Gastroenterology	
Internal Medicine - General	
Hematology (at par with faculty)	
Infectious Diseases	
Nephrology	
Neurology	
Pharmacology	
Respirology	
Rheumatology	

There are a number of specialties/subspecialties where there is no comparison possible - Pediatric and Adult Intensive Care, Neurosurgery, Cardio-thoracic Surgery, and Dermatology.

- For both Orthopedic Surgery and General Surgery, the size of the salary enhancement in 1997/98 resulted in their moving from behind to considerably ahead of their private practice counterparts.

The COM is proposing that the following salary enhancements are necessary commencing in the 1999/00 fiscal year (see Table 7.4.2.2.3). The impact of the enhancements on the comparison with private practice net pre-tax incomes would be as follows if implemented:

Specialty/Subspec	97/98 Private Practice Inc.	97/98 Faculty Inc.	Salary Increase	Revised Faculty Inc.	Revised Index
Family Medicine	88,740	109,261	5,000	114,261	0.78
Psychiatry	166,044	137,679	36,500	174,179	0.95
Pediatrics	118,018	130,726	22,454	153,180	0.77
Pathology	N/A	122,458	5,000	127,458	N/A
Community Health	N/A	122,689	10,000	132,689	N/A
Microbiology	N/A	98,199	5,000	103,199	N/A
Physical Medicine	N/A	153,471	20,000	173,471	N/A

There are only private practice comparisons for Family Medicine, Psychiatry and Pediatrics. In each case the salary increase would result in faculty being paid more than their private practice counterparts. In fact, Family Medicine and Pediatrics are already significantly ahead of private practice.

The index is the ratio of private practice net pre-tax income to revised faculty income. For example, in the above Table Family Medicine private practice net pre-tax income is 78% of revised faculty income.

The number of physicians included in the comparison as reported in Appendix 3(b) for the 1997/98 year are as follows:

	Private Practice	Faculty
Family Medicine	237	8
Psychiatry	18	8.8
Pediatrics	13	8

Private practice data excludes COM, Community Clinics and Alternate Payment projects. Only physicians whose billings exceed \$10,000 in each quarter of the year were included in the private practice data. The Pediatrics data excludes Pediatrics Intensivists who are in a

separate category, with 4 faculty and no private practice comparisons.

For Pathology, Community Health, Microbiology, and Physical Medicine, there is no private practice comparison, and the determination of the increase appears to be somewhat arbitrary. The rationale for these services receiving an increase has not been explained, nor has the dollar amount of the increase.

Of all of the increases proposed for 1999/00, Psychiatry is the only one where the data would indicate that an increase is warranted, and even in this case, the amount of the increase is excessive, if the objective is to be at par with private practice for this service. Unless more data is presented, there is presently no case for the other six services receiving an increase, other than the fact that "everyone else is getting an increase."

In addition to the increases analyzed above, the COM is proposing about \$1.0 million in salary increase for Medical Imaging, an increase of about 63%, compared to the present expenditure level. The rationale for the proposed increase is that these faculty would then be at the same rates as their private practice colleagues, who are paid by contract from the Saskatoon Health District.

As previously mentioned, more rigour should have been used in determining appropriate compensation levels for each of the specialties/subspecialties. The annual cost of the proposed increases for 1999/00 amount to about \$2.15 million (\$1.15 million for departments as noted and \$1.0 million for Medical Imaging), which should be reconsidered in light of the data.

Comparison of Changes in Compensation
Private Practice vs. College of Medicine
Between 1996/97 and 1997/98

Table 7.5.2 (p. 1 of 2)

Specialty/Subspecialty	Private Practice				College of Medicine				Private Practice to College Index	
	1997/98 Average	1996/97 Average	Increase (Decrease)	% Incr (Decr)	1997/98 Average	1996/97 Average	Increase (Decrease)	% Incr (Decr)	1997/98 Index	1996/97 Index
Anaesthesia	159,877	157,256	2,621	1.7%	183,691	189,230	(5,539)	-2.9%	0.87	0.83
Family Medicine - Metro	88,740	85,121	3,619	4.3%	109,261	108,995	266	0.2%	0.81	0.78
Obstetrics & Gynecology	182,170	184,187	(2,017)	-1.1%	142,003	124,970	17,033	13.6%	1.28	1.47
Ophthalmology (2)	292,652	296,588	(3,936)	-1.3%	194,427	139,757	54,670	39.1%	1.51	2.12
General Pediatrics	118,018	114,495	3,523	3.1%	130,726	127,336	3,390	2.7%	0.90	0.90
Intensivist Pediatrics	N/A	N/A	N/A	N/A	203,778	204,232	(454)	-0.2%	N/A	N/A
Psychiatry	166,044	151,007	15,037	10.0%	137,679	141,614	(3,935)	-2.8%	1.21	1.07
Neurosurgery (2)	N/A	N/A	N/A	N/A	288,683	186,779	101,904	54.6%	N/A	N/A
Orthopedic (2)	213,010	207,043	5,967	2.9%	233,773	159,670	74,103	46.4%	0.91	1.30
General Surgery (2)	159,661	145,674	13,987	9.6%	201,206	128,157	73,049	57.0%	0.79	1.14
Cardio Thoracic	N/A	N/A	N/A	N/A	360,697	391,034	(30,337)	-7.8%	N/A	N/A
Agriculture (1)	157,727	153,536	4,191	2.7%	142,782	137,852	4,930	3.6%	1.10	1.11
Cardiology	290,722	314,796	(24,074)	-7.6%	147,331	147,556	(225)	-0.2%	1.97	2.13

Footnotes:

- 1) There are no private practice comparisons for Agriculture, Endocrinology, Haematology, Infectious Diseases, and Pharmacology, and therefore General Internal Medicine is used as the private practice benchmark.
- 2) The 1997/98 College of Medicine averages reflect a service supplement for Ophthalmology, Neurosurgery, Orthopedic, and General Surgery

Comparison of Changes in Compensation
Private Practice vs. College of Medicine
Between 1996/97 and 1997/98

Table 7.5.2 (p. 2 of 2)

Specialty/Subspecialty	Private Practice----->				College of Medicine----->				Private Practice to College Index	
	1997/98 Average	1996/97 Average	Increase (Decrease)	% Incr (Decr)	1997/98 Average	1996/97 Average	Increase (Decrease)	% Incr (Decr)	1997/98 Index	1996/97 Index
Dermatology	138,242	122,014	16,228	13.3%	N/A	133,436	N/A	N/A	N/A	0.91
Endocrinology (1)	157,727	153,536	4,191	2.7%	139,852	133,753	6,099	4.6%	1.13	1.15
Gastroenterology	235,629	230,929	4,700	2.0%	128,457	120,164	8,293	6.9%	1.83	1.92
Internal Medicine - Gen.	157,727	153,536	4,191	2.7%	100,129	95,257	4,872	5.1%	1.58	1.61
Haematology (1)	157,727	153,536	4,191	2.7%	158,211	146,366	11,845	8.1%	1.00	1.05
Intensive Care	157,727	153,536	4,191	2.7%	N/A	128,475	N/A	N/A	N/A	1.20
Infectious Diseases (1)	157,727	153,536	4,191	2.7%	117,874	113,250	4,624	4.1%	1.34	1.36
Nephrology	210,726	210,722	4	0.0%	130,336	115,609	14,727	12.7%	1.62	1.82
Neurology	166,815	169,944	(3,129)	-1.8%	130,458	136,610	(6,152)	-4.5%	1.28	1.24
Pharmacology (1)	157,727	153,536	4,191	2.7%	132,155	117,396	14,759	12.6%	1.19	1.31
Respirology	147,783	169,612	(21,829)	-12.9%	139,300	130,595	8,705	6.7%	1.06	1.30
Rheumatology	184,221	178,334	5,887	3.3%	115,784	111,211	4,573	4.1%	1.59	1.60

Footnotes:

- 1) There are no private practice comparisons for Agriculture, Endocrinology, Haematology, Infectious Diseases, and Pharmacology, and therefore General Internal Medicine is used as the private practice benchmark.
- 2) The 1997/98 College of Medicine averages reflect a service supplement for Ophthalmology, Neurosurgery, Orthopedic, and General Surgery.

7.5.3 Comparison with Other Medical Schools

The Terms of Reference ask for a comparison of faculty compensation levels with other Medical Schools. In attempting to make this comparison, the ACMC was contacted to determine whether an annual compensation survey exists. The Association indicated that the last time a survey had been done was in 1992/93, some six years ago. Given the period of time that has elapsed, the information is viewed as outdated.

A copy of the survey, the 40 page completion guide, and the final report was obtained and reviewed, to determine whether a survey could be conducted within the scope, schedule and budget of this project. It was evident that to produce a credible comparison would be an extensive national undertaking, and could not be realistically achieved within the constraints of this project.

A compensation survey of Canadian medical schools should be conducted on a regular basis through the office of Research and Information Services of the ACMC. All of the Faculties of Medicine could benefit from this information, and it should result in informed decision-making in regards to establishing compensation levels at the various Universities.

The ACMC should be asked to undertake a faculty compensation survey on a priority basis. The results of this survey should factor in revised compensation levels of the COM.

As a further attempt to address a comparison with other medical schools, the LCME was contacted, to determine whether the annual questionnaire completed by Canadian medical schools contains sufficient detail to make a comparison. This information was found to be too summarized and, therefore, could not be used for this purpose.

7.5.4 Full and Part-Time Faculty

As stated in the College Profile in Section 7.4.1, there are about 865 faculty at the COM, as follows:

Full-time:	
Tenured	151
Without Term	<u>94</u>
Subtotal - Full-time	<u>245</u>
Part-time	<u>620</u>
Total faculty	<u>865</u>

Full-time tenured faculty means that the staff member's standing is as defined by the terms and conditions of the collective agreement between the UofS and its Faculty Association. The salary of full-time tenured faculty is paid from the Operating Fund.

Full-time "without-term" faculty means that the staff member's standing is as defined by separate agreement. Under these agreements, there is an initial probationary period, after which "without-term" appointments are of an indefinite duration and terminable on 90 days notice by either party at any time. The agreement specifies the distribution of time between academic and clinical services and research. The academic component of salary of without-term faculty is paid from the CPP, if it is not otherwise supported by the Operating or CSF.

Part-time faculty are private practice community-based physicians who provide teaching to medical students in clinical settings. Of the 620 part-time faculty on the roster, there are about 300 annually that provide some teaching services, for which they are paid from the CSF.

7.5.5 Unfunded Academic Activity

A detailed salary spreadsheet was prepared for each of the 1996/97 and 1997/98 fiscal year actual results, the 1998/99 Budget, and the 1999/00 Forecast. The purpose of the spreadsheet is to provide the distribution of total salaries of each faculty member with the COM, by Department by Fund and within each Fund, the academic and service payment components.

Appendix 2(a) through (d) provides the summary of the distribution of salaries by department by Fund, and within each Fund, the components of academic and service salaries for the 1996/97 through 1999/00 years respectively. The determination of the allocation between academic and service portions of salaries is based on the following logic:

- Full-time tenured faculty of the University are paid their academic salaries out of the Operating Fund, with any additional income being reported as service income within the other applicable Funds.
- Full-time "without-term" faculty are paid the academic component from the CPP, if not otherwise funded by the Operating or CSF. The academic portion is calculated as if the University's collective agreement had been applied to these staff, and the remainder of their incomes is allocated to service.
- Academic Services provided by part-time staff are paid from the CSF.

For the fiscal year ended April 30, 1998 the distribution of academic and service components of the faculty salaries by Fund, as reported on the "bottom line" of Appendix 2(b) is as follows:

Fund	Academic	Clinical	Total
Operating	10,351,953	119,826	10,471,779
Clinical Services (funded by SaskHealth)	1,817,291	3,760,351	5,577,642
Clinical Practice Plan	1,414,807	7,315,622	8,730,429
Other Specific Purpose	368,427	1,133,401	1,501,828
Research	218,530	147,410	365,940
Subtotal	2,001,764	8,596,433	10,598,197
Total	14,171,008	12,476,610	26,647,618

For academic services of faculty to be fully paid by the Operating Fund would mean the following:

Action Required	Academic	Employee Benefits (@ 8.2% est.)	Total
Transfer from SaskHealth to Post-Secondary re academic services paid by CSF	1,817,291	149,018	1,966,309
Eliminate the subsidization of academic services - increase Post-Secondary funding directed to the COM	2,001,764	164,145	2,165,909

The options in regards to academic services funding are as follows:

1. Continue to fund certain academic services of the COM through the CSF.

Advantage

Is effective and efficient, as there is only one Fund that addresses aspects of COM funding not covered by other sources. Under this option, the agreement between Saskatchewan Health and the COM could identify the amount of academic services to be provided, and the consultation required with the Department of Post-Secondary Education.

Disadvantage

Academic services are the jurisdiction of Post-Secondary Education.

2. Establish an Academic Services Fund (ASF) for the COM under Post-Secondary Education, for specified academic services. Transfer present academic funding from the CSF to the ASF.

Advantage

All of the academic services funding under this model would reside with Post-Secondary Education.

Disadvantage

It is difficult to separate the academic and clinical activity of faculty positions. Changes in mix of activity in any given year would require funding adjustments between the two Ministries, as there would now be two Funds (CSF and ASF).

3. Increase the base funding of the UofS for academic services that are now being funded through the CSF, CPP, Other Specific Purpose, and Research Funds, with the commitment by the UofS that such increase be directed to the COM Operating Fund.

Advantage

Academic Services form part of the base funding of the COM in the Operating Fund, and CSF funding is then only in regards to Clinical Services.

Disadvantage

As the UofS makes budget allocation adjustments, any funding that is included in the base funding is vulnerable to these changes.

Section 7.9 includes a recommendation that the first option above be adopted, with specific academic services and consultation with Post-Secondary Education to be included in the CSF Contract.

7.6 Compensation of PGME Trainees

Postgraduate medical education 1998 salaries of the UofS are compared to seven other provinces in table 7.6 for postgraduate years 1 through 6.

With the index of Saskatchewan set to 100%, a comparison can be made of those provinces where salaries are higher (index >100%), and those where salaries are lower (index <100%).

The data indicates that Saskatchewan is between 1.5% (PGY1) to 3.1% (PGY6) below the national average. The salaries of Ontario, British Columbia and Quebec are considerably higher, raising the national average.

Saskatchewan is slightly higher than the median for PGY1 and PGY2, and slightly below the median for PGY3 through PGY6. Alberta is at the median in all six years.

Using the median as the benchmark, the data indicates that compensation of Saskatchewan PGME trainees is competitive with the rest of Canada.

Post Graduate Medical Education Salary Survey
1998

Table 7.6

Province	PGY1	%	PGY2	%	PGY3	%	PGY4	%	PGY5	%	PGY6	%
Saskatchewan	31,735	100.0%	34,609	100.0%	37,481	100.0%	40,338	100.0%	43,177	100.0%	46,007	100.0%
British Columbia	37,658	118.7%	42,010	121.4%	45,779	122.1%	49,277	122.2%	52,993	122.7%	56,578	123.0%
Alberta - Edmonton	31,625	99.7%	34,372	99.3%	37,811	100.9%	40,561	100.6%	43,999	101.9%	46,749	101.6%
Alberta - Calgary	31,625	99.7%	34,372	99.3%	37,811	100.9%	40,561	100.6%	43,999	101.9%	46,749	101.6%
Manitoba	30,417	95.8%	32,351	93.5%	35,944	95.9%	38,710	96.0%	41,476	96.1%	44,242	96.2%
Ontario	37,974	119.7%	44,326	128.1%	47,019	125.4%	50,204	124.5%	53,538	124.0%	56,672	123.2%
Quebec	33,596	105.9%	36,868	106.5%	40,654	108.5%	44,425	110.1%	47,440	109.9%	49,882	108.4%
Newfoundland	30,176	95.1%	33,048	95.5%	35,921	95.8%	38,796	96.2%	41,670	96.5%	44,544	96.8%
Nova Scotia	30,513	96.1%	33,102	95.6%	36,219	96.6%	38,905	96.4%	41,905	97.1%	44,702	97.2%

National average	32,208	101.5%	35,381	102.2%	38,608	103.0%	41,563	103.0%	44,651	103.4%	47,443	103.1%
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Median	31,625	99.7%	34,372	99.3%	37,811	100.9%	40,561	100.6%	43,999	101.9%	46,749	101.6%
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Source: University of Saskatchewan

7.7 University/Government Reporting Requirements

7.7.1 Overview

In order to assess the adequacy of the current financial and resource allocation reporting requirements to government and the University and recommend any modifications deemed necessary to ensure that financial accountability is sufficient, the following procedures were undertaken:

- Sample copies were obtained of current financial and resource allocation reporting requirements to government, the University and other stakeholders.
- The objectives of the reporting requirements were identified through discussion and review of documentation (ie. for approval, accountability, information, etc.).
- A meeting was held with the University's Finance and Administration office and the Auditor General's office to explore options for enhanced annual financial reporting.

7.7.2 Current Report Requirements

a) University of Saskatchewan Budget

Distribution: Board of Governors, and available by others upon request. Contains only the Budget of the General Operating Fund for the entire University (ie. the portion that is funded by the Department of Post-Secondary Education).

Purpose: For approval by the University Board of Governors.

b) Clinical Services Fund Report

Distribution: Concurrently to Saskatchewan Health and the University (Finance and Administration).

Purpose: The College uses this information for funding decisions and accountability reporting. The University ensures that this information is consistent with their financial reporting system, and that the Fund is viable. The link between the University and the COM is that the VP-Finance and Administration is a member of the Dean of Medicine's Advisory Committee on College Resources where this information is discussed. The CSF does not form part of the University Budget and it therefore does not receive formal approval at the Board level.

c) Practice Plan Reports

Distribution: Complete report provided to the Dean's office and the University (Finance and Administration). Departmental reports provided to each of the departments of their specific information. Academic Heads do not see other department's information.

Purpose: Each of the departments within the COM is considered as a professional

"partnership," and the departmental CPP statement is their annual financial report. The departmental statement is used by the Academic Heads to manage the financial affairs of their portfolio. The Dean's office uses the complete statement to ensure overall viability of the Practice Plan. The University ensures that the information is consistent with their financial reporting system, and that the Plan is viable. The Practice Plan does not form part of the University Budget, and it therefore does not receive formal approval at the Board level.

d) Annual Liaison Committee on Medical Education (LMCE) Reports

Distribution: To the Liaison Committee on Medical Education

Purpose: Research, Accreditation

e) University of Saskatchewan Statistics (prepared by the University Studies Group)

Distribution: Available upon request to anyone. Contains a wealth of information on actual enrollments, staffing profiles, demographic profiles, and net operating expenditures by Budget Centre.

Purpose: Provides an historical account of University statistics. Used for planning and research purposes.

f) Report on Funding for Research Projects and Contract Research

Distribution: Vice President, Academic Office.

Purpose: Provides an historical account of all of the research grants received in the most recent fiscal year, by project and source of funding for the grant.

7.7.3 Future Directions

The inventory of reports confirms that in the past, there has not been a single source of financial information that provides the "financial position and results of operations" of the COM. In discussions with the UofS's Finance and Administration office and the Provincial Auditor's office, it was determined that the following enhancements are reasonably attainable:

To be included in the audited financial statements:

- Supplementary Schedule - new - appended to the audited financial statements and contains segmented reporting of *total* revenues, expenditures, and fund balance by each College within the University. The grand total figures flow into the Statement of Operations.

Additional supporting schedules that will be prepared, but will not be part of the audited financial statements due to their detailed nature:

- Fund Statement - Revenue, Expense, and Fund Balance by *College* - new - a separate statement of Operations for each Fund (ie. Operating Fund, Specific Purpose, Research, Trust, etc.) which contains the revenue, expenditure, and fund balance by College. [For each Fund, the various Colleges of the University are reported in the columns across the page, with the last column being the total, and the objects of revenue, expenditure, and fund balance are in the rows].
- College Revenue, Expense, and Fund Balance Statement by *Fund* - new - a separate statement for each College containing the revenue, expenditure, and fund balance by Fund. [For each College, the various Funds are reported in the columns across the page, with the last column being the total, and the objects of revenue, expenditure, and fund balance are in the rows].

The unpublished supporting schedules will have an audit trail to the *published* supplementary schedule. The College Statement by Fund will have high utility as a "general purpose" statement of the COM, providing a complete picture of the revenues, expenditures, and fund balance for the numerous stakeholders of the COM. An example of this type of statement can be found in Appendix 1.

Consolidated Budget for approval by the Board

- The University's annual Budget in the future should be expanded to include all Funds (ie. Not only the Operating Fund), and also the total revenue and expenditure budget of each of the Colleges. The year-end audited financial statements should report on the financial performance of each of the Funds, and the total revenue and expenditures of each of the Colleges in comparison to the Budget.

7.8 Options for Alternate Payment

7.8.1 Overview

In order to assess alternative funding arrangements for the COM, determine the advantages and disadvantages of each, and recommend the preferred arrangements to address future sustainability and accountability, the following procedures were undertaken:

- A request was made to the Universities of Manitoba, Dalhousie, and Memorial, to obtain their 1995/96 and 1996/97 Canadian Annual Medical School Questionnaire.
- Alternative funding arrangements were considered within the overall findings of this project.

7.8.2 Comparison with Other Medical Schools

Table 7.8.2 identifies the categories of revenue (marked with a "x") that are reported within the Canadian Annual Medical School Questionnaire for each of four Universities. The following observations can be drawn from the Table:

- Saskatchewan is the only College of the four that does not report tuition revenue. Tuition is collected centrally by the UofS, and an overall funding allocation is made to the COM.
- Manitoba and Nova Scotia do not receive financial support from the Department of Health, as the support flows from the Ministry of Education. In Newfoundland, the financial support flows from the Ministry of Health, and none is received from the Ministry of Education.
- There is considerable variation in the other sources of funding between the four Colleges.

Most non-profit organizations receive their funding from a variety of sources. The question is whether accountability of the COM could be improved for the Provincial funding component by having one Ministry rather than two being the funding source.

Options for consideration were presented in Section 7.5.5, with recommendations provided in 7.9.1 (c) and 11.8.

Canadian Annual Medical School Questionnaire
Revenue and Expenditure Summary
Fiscal Year 1996/97

Table 7.8.2

Description	Saskatchewan	Manitoba	(Dalhousie) Nova Scotia	(Memorial) Newfoundland
Revenue				
Tuition and Fees				
M.D. Program		X	X	X
Other (Identify)				
Graduate Students		X		X
Post Graduate Programs		X		
School of Med. Rehab.		X		
Miscellaneous				X
Provincial Government/Ministry of Health	X			X
Provincial Government/Ministry of Education	X	X	X	
Grants & Contracts (Direct)				
Federal Grants	X	X	X	X
Provincial Grants	X	X	X	X
City/Local Grants	X	X	X	
Foreign Grants	X	X	X	X
Other				
Practice Plan			X	
Internal University	X	X	X	
Private for profit industry	X	X	X	X
National Foundations/Societies		X		X
Provincial Foundations/Societies		X		
Unaffiliated Hospitals & Universities		X		
Special Projects		X		
Indirect cost recovery (overhead)		X		X
Medical service	X	X		X
Gifts/donations			X	X
Trusts & endowment income			X	X
Affiliated clinical sites		X	X	X
Other revenues				
Sales and service		X		X
Other				
Other department sources	X		X	
Medical service			X	
Telemedicine				X
Parking permits				X
Photography fees				X
Equipment & Renovations		X		
Miscellaneous billings		X		

7.9 Recommendations on Funding, Compensation and Reporting

7.9.1 Funding

a) Forecasted 1998/99 Fund Balances

Appendix 1(c) forecasts that with the exception of the CSF, all other Funds within the COM will be in a surplus balance at April 30, 1999. The CSF is anticipated to be in a deficit position of \$910,000 by year's end.

The accumulated Fund balance of the Operating Fund available to the COM is expected to be about \$1.377 million, of which about \$1.163 million is general contingency, and \$0.214 is Medical Research Council contingency.

Recommendation:

We recommend that the projected deficit of the CSF at April 30, 1999 be eliminated on a one-time basis by Saskatchewan Health (\$533,705) & UofS (\$376,295).

Saskatchewan Health:

- Provide full funding of PGME salary increases on the basis that funding of PGME salaries are a provincial responsibility.

- 96/97 shortfall in funding (\$180,444 for 97 and 98)	\$360,888
- shortfall in funding for further increases in 97/98	<u>172,817</u>
- One time funding - Department of Health	<u>533,705</u>

University of Saskatchewan:

- A one time transfer from the COM's accumulated Operating Fund general contingency, to cover the net incremental costs of program enhancement decisions taken by the COM without funding consent by Saskatchewan Health. This transfer would draw down the COM's general contingency account to about \$786,000.

	<u>376,295</u>
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Elimination of projected accumulated deficit - April 30, 1999	<u>\$910,000</u>
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b) 1999/00 Funding

Section 7.4.2.2 contains an itemized list of the funding request being made by the COM for the 1999/00 fiscal year, amounting to approximately \$4.6 million.

Of the \$4.6 million request, almost \$2.2 million is in regards to proposed salary increases for 1999/00 (\$1.2m for a number of departments; \$1.0m for Medical Imaging). This \$2.2 million, together with the \$2.0 million (various services), and \$280,000 (Neurosurgery) previously provided by Saskatchewan Health over the past two years, would bring the overall total to about \$4.5 million for salary increases.

The data in Section 7.5 indicates that using private practice as a benchmark, that some substantial adjustments were warranted, however, it is apparent that both internal and external equity have been further compromised by the magnitude of some of the adjustments. The overall cost of faculty compensation adjustments to ensure the ability to recruit and retain highly qualified faculty and restore equity we deem as being less than the total of \$4.5 million being suggested by the COM.

The funding request also identified a number of program enhancement requests, which have not been examined within this Review. The merits of each should be considered jointly between the COM, Saskatchewan Health and the Saskatoon Health District.

Another observation is that the faculty of the COM are presently subsidizing academic activity of the UofS through the CPP, Other Specific Purpose, and Research activity in the amount of about \$2.2 million per year, as documented in Section 7.5.5, which is addressed in the recommendations below.

Recommendation:

We recommend that Saskatchewan Health increase funding by \$2.909 million for the 1999/00 fiscal year.

Fully fund academic activity provided on a subsidized basis through the CPP, Other Specific Purpose, and Research Funds.	\$2,166,000
PGME increases	
-1996/97 shortfall in funding	180,444
-1997/88 shortfall in funding	172,817
Infrastructure support - Associate Dean Clinical Services, Associate Dean Research, and Associate Dean Education	<u>390,000</u>
Total funding increase	<u>2,909,261</u>

Recommendation:

We recommend that funding for the academic activity be applied as follows:

To the existing shortfall in base funding	\$1,204,000
To faculty compensation	887,000
To supply cost increases	<u>75,000</u>
Total academic activity funding per above	<u>\$2,166,000</u>

Recommendation:

We recommend that an equitable solution for faculty compensation including Medical Imaging, be accomplished within an amount of \$3,167,000 (\$2,000,000 of funding provided to date plus \$280,000 previous Neurosurgery funding, and \$887,000 new funding). To achieve equity would require the establishment of a defensible compensation policy for all faculty (including Neurosurgery and Medical Imaging).

On an overall basis, this recommendation would result in meeting about 71% of the total compensation request (\$3.167m funding/\$4.454m request).

The 887,000 of new funding for faculty compensation should not be flowed until there is a commitment by the COM to undertake a comprehensive compensation review, and re-open previous salary agreements. The completion date of a compensation review, including a national survey, will extend beyond April 1, 1999. The results of the compensation review should be implemented retroactively to April 1, 1999 within the funding envelope provided.

Recommendation:

We recommend that appropriate consultation occur between the College of Medicine, Saskatchewan Health, and the Saskatoon Health District regarding future program enhancement requests as identified in Section 7.4.2.2.

Number of Funds

Section 7.5.5 identified three options in regards to academic services funding, and provides the advantages and disadvantages of each. The identified options are:

- Continue to fund certain academic services of the COM through the CSF.
- Establish an Academic Services Fund (ASF) for the COM under Post-Secondary Education for specified academic services. Transfer present academic funding from the CSF to the ASF.
- Increase the base funding of the UofS for academic services that are now being funded through the CSF, CPP, Other Specific Purpose, and Research Funds, with the commitment by the UofS that such increase be directed to the COM Operating Fund.

Recommendation:

It is recommended that certain academic services of the College of Medicine continue to be funded through the Clinical Service Fund, with the contract between Saskatchewan Health and the University of Saskatchewan to include the specified academic services to be provided, and a requirement for consultation with the Department of Post-Secondary Education in regards to actions that are under consideration.

7.9.2 Compensation

a) Compensation Policy

Section 7.5 addressed the perceptions and historical events leading to the implementation of salary adjustments for faculty in the 1997/98 and 1998/99 fiscal years. The adjustments were made in the absence of a salary survey comparing the UofS COM to other Canadian medical schools. Furthermore, a compensation policy was not established in advance to ensure that internal and external equity would be achieved. In addition, advice from human resource professionals was not accessed in determining the adjustments.

Recommendation:

It is recommended that professional human resources advice be utilized to establish an appropriate compensation policy for the College of Medicine, with specified objectives to ensure that internal and external equity is achieved, and that recruitment and retention of highly qualified faculty is sustainable over the long term. No new funding for faculty compensation in 1999/00 should be advanced until a commitment is made to establish and implement a comprehensive faculty compensation policy.

The compensation policy should consider the following:

- Salary set at a specified percentile relative to other Canadian medical schools, which are the main competitors and reference points for faculty (external equity).
- Set to specified index levels in relation to private practice incomes for each Department. The index levels may vary, depending on the specific circumstances of each Department (external equity).
- Salary set on a "relative value" basis which would establish compensation relative to performance in the areas of academic services, clinical services and research (internal equity).

b) Salary Survey

Recommendation:

It is recommended that the Association of Canadian Medical Colleges undertake a national, faculty compensation survey of Canadian medical schools on a priority basis, and that the results of this survey provide an additional basis for finalization of compensation levels for the University of Saskatchewan College of Medicine.

c) Previous Salary Adjustments

Recommendation:

It is recommended that in order to achieve internal and external equity, that compensation adjustments made to date be open to revision, such that the total compensation increases for all applicable College of Medicine faculty be achieved within the total funding of \$3,167,000.

d) Approval of Faculty Compensation

Recommendation:

It is recommended that the compensation policy of College of Medicine faculty be formally approved by the Finance and Audit Committee of the University of Saskatchewan, to ensure that the appropriate due diligence has been applied, and that an equitable solution has been achieved.

e) Faculty Agreements

Section 7.4.1 (b) made the observation that faculty agreements are generally silent on the expected distribution between academic, clinical service, and research activities.

Recommendation:

It is recommended that the faculty agreements of full-time tenured, full-time without-term, and part-time faculty be revised, with the objective of ensuring that they include the appropriate provisions and proportions for the academic, clinical and research services to be provided, the related compensation, and other terms and conditions as appropriate.

7.9.3 Reporting

a) Budget Process and Approval

Section 7.4.3 reviewed the present Budget process and approval levels. The observation was made that at the present time, the Board approves only 21.7% of the COM's total annual budget (the Operating Fund), while 45.0% is approved by other stakeholders (CSF and CPP), and 33.3% is not formally budgeted.

While it is understood that there are a number of checks and balances in the present budget preparation and approval process, there is nevertheless a level of accountability that needs to be exercised by the Board that includes a good understanding of all resources administered by the UofS.

Recommendation:

We recommend that the University of Saskatchewan annual budget be a consolidated budget, inclusive of all of the Funds of all of the Colleges, and not only the Operating Funds.

We recommend that budgets be prepared for key projects and activities that are planned by the College of Medicine in regards to Other Specific Purpose, Trust, Research and Endowment Funds. There are approximately 750 accounts within these Funds, with designated signing authorities. Presenting a plan for the top 20 accounts (or other appropriate sample), as measured by the account balance at the end of the previous year, will provide a useful indication of the types of activities that will be undertaken, and allow a year-end report to be presented on accomplishments in relation to the plan.

That the annual University of Saskatchewan audited consolidated financial statements include the approved consolidated budget as a reference column in the Statement of Operations.

That the College of Medicine prepare on an annual basis, a management discussion and analysis document of the College of Medicine's segment of the consolidated financial statements, explaining significant variances between actual results and the budget, and also from one year to the next.

That the College of Medicine implement a planning cycle that extends beyond the upcoming year to ensure that future key directions are established and to have a better opportunity to anticipate and adjust to change.

b) Financial Statements

The inventory of reports in Section 7.7 confirms that in the past, there has not been a single source of financial information that provides the "financial position and results of operations" of the COM. In discussions with the UofS's Finance and Administration office and the Provincial Auditor's office, it was determined that the following recommendations are reasonably attainable:

i) To be included in the audited financial statements of the UofS:

- Supplementary Schedule - new - to be appended to the audited financial statements and contain segmented reporting of total revenues, expenditures, and fund balance by each College within the University. The grand total figures flow into the Statement of Operations.

ii) Additional supporting schedules to be prepared, but will not be part of the audited financial statements due to their detailed nature:

- Fund Statement - Revenue, Expense, and Fund Balance *by College* - new - a separate statement of Operations for each Fund (ie. Operating Fund, Specific Purpose, Research, Trust, etc.) which contains the revenue, expenditure, and fund balance for each College. [For each Fund, the various Colleges of the University are reported in the columns across the page with the last column being the total, and the objects of revenue, expenditure, and fund balance are in the rows.]
- College Revenue, Expense, and Fund Balance Statement *by Fund* - new - a separate statement for each College containing the revenue, expenditure, and fund balance by Fund. [For each College, the various Funds are reported in the columns across the page with the last column being the total, and the objects of revenue, expenditure, and fund balance are in the rows].

The unpublished supporting schedules will have an audit trail to the *published* supplementary schedule. The College Statement by Fund will have high utility as a "general purpose" statement of the COM, providing a complete picture of the revenues, expenditures, and fund balance for the numerous stakeholders of the COM.

8.0 ACADEMIC MEDICAL-INDUSTRIAL COMPLEX

"This conjunction of an immense military establishment and a large arms industry is new in the American experience...We recognize the imperative need for this development. Yet we must not fail to comprehend its grave implications...In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the 'military-industrial complex.' The potential for the disastrous rise of misplaced power exists and will persist."

-Dwight D. Eisenhower, January 17, 1961

8.1 Introduction

The past quarter century has seen the rise of a particular type of "industrial complex" throughout the developed world. Not unlike the military-industrial complex, an equally great potential for influence on public policy has come from the "medical-industrial complex."⁷ The Academic Medical-Industrial Complex was first named by the Health Policy Advisory Committee in the United States. It described newly created, giant technologic-academic centers that came to dominate the health care industry in the decades after World War II.⁸

Driven, amongst other things, by image, quest for market share, or scientific ideals, Academic Medical-Industrial Complexes have created unrelenting demand for new ways to treat and diagnose disease. The post-war years have seen a veritable explosion in therapeutics and new health care technologies. Medical schools and their affiliated teaching hospitals have become intimately and centrally involved in both the development and application of these technologies and medications for the treatment of disease and disability. This research may or may not include the medical school's basic sciences. Researchers and clinical staff not infrequently are contracted and paid handsomely by manufacturers to conduct clinical trials on new devices and products, and to endorse these new technologies and products to the medical community or to third-party payers. Not surprisingly, Academic Medical-Industrial Complexes have become

renowned and rewarded for applications of new technologies for the treatment of an increasingly select group of patients.

Academic Medical-Industrial Complexes have been committed to innovation and to challenging current practices and standards of care. Not surprisingly, medical education for students and residents in such environments expose trainees to innovative technology, yet may create an excessive reliance on tests, technology, and an extensive, specialized consultant base. Furthermore, the socialization process within these centres teaches trainees that the employment of complex, specialized procedures is the optimal way to treat patients. This exposes students of medicine to a limited range of patients and, explicitly or not, steers graduates away from careers which are outside of academic and urban centres, and away from less differentiated, generalist careers. Under the worst circumstances, this creates academic elitism and the belief that practising outside of the AMIC is only for the unworthy. Said in another way, rural practice is for those who do not "make it here."

8.2 Academic Medical-Industrial Complex Interactions with Clinical Education

The emergence of the Academic Medical-Industrial Complex has dramatically influenced the face of medicine and medical education. Four major changes in medicine have affected clinical teaching in the last century.⁹ The first was the establishment of university control over hospitals and clinical faculties and the replacement of the practitioner by the full-time academic clinical investigator, as role models for students. Equally important was the steady expansion of more sophisticated technology which, propelled by prosperity, promoted specialization. A third element was the passing of control from individuals and philanthropists to third-party payers or governments. Perhaps the most important of all was a period of unusual prosperity and an increased expectation and willingness on the part of the public to spend money in pursuit of its own health and longevity.

University teaching hospitals in communities with medical schools have evolved to Academic Medical-Industrial Complexes from previously intimate, domestic, institutions dependent on gifts and donations for survival, to vast distribution centres for high technology that are run on business principles, more so of course in the US than in Canada.

Large teaching hospitals admit patients that are sicker and have a narrower range of problems than formerly, many needing complex interventions. Hospitalized patients now demonstrate less than ever the natural history of disease. Bedside teaching is done increasingly by those highly trained in subspecialty areas and selected in consideration of the problem presented by the patient. The strong preference of the reward system and the character of practise has changed the culture to encourage a greater use of tests and procedures, while often discouraging listening and thinking. The generalist attending physician has become almost an anachronism.

Clinical teaching has clearly changed from a focus on UGME to one on PGME, that is to say specialty training for residents and subspecialty training for fellows. This has followed from the ever-more demanding requirements for specialty certification, the greater desire of young physicians for specialty status, propagated by the need of hospital-based faculty and specialists to have housestaff to look after inpatient care.

8.3 Challenges

Atwater has made the interesting observation that we are attempting to train too many physicians, with too few patients, who stay in the hospital too short of a time, and who are too often unavailable, because they are too sick or elsewhere having tests or treatments.⁹ Neither students nor house officers have the personal relationship or the responsibility that they formerly did. This is not an empirically documented fact, yet seems to be intuitively on target.

Many argue that too many young trainees are directed towards more lucrative subspecialties in which they can limit their practice to pre-selected patients, with problems amenable to specific and economically rewarding procedures or treatments. This avoids having to deal with those with patients less-defined, often more complex and time-consuming problems. In short, there is concern that we are not training physicians for the real world that we live in or for the care that we want.

The Academic Medical-Industrial Complex has grown more unwieldy in these times of fiscal restraint and intense desire for efficiency. In the extreme examples, as are found in the US multi-payer system, such centres threaten to engulf owners, economically and professionally. In Canada, fiscal restraint and fundamental changes in health services delivery are forcing redefinition and new undertakings of the academic health centre.

8.4 Closer to Home

Most Canadian Provinces have large and widely dispersed rural populations. Recruiting and retaining physicians in rural Canada has been an interminable problem for decades. Many argue that poor distribution is the primary characteristic of this problem, rather than absolute shortage of physicians.¹⁰ Physicians trained in large, technologically complex and specialized academic health sciences centres, the Canadian versions of the Academic Medical-Industrial Complexes, arguably may not have the generalist skills required to practice in more challenging forms of medicine in rural settings. Furthermore, trainees may be unmotivated to practice in rural environments because of the socialization process inculcated in academic medical centres. In many Provinces, Saskatchewan included, trainees are perhaps unaware of the opportunity and fulfilment that exists in rural practice.

The social responsibility of an academic health centre can be gauged by its readiness to serve at every level of the health care system. Accordingly, privileged investment in tertiary care sanctuaries - symbolized by academic health sciences centres, come at a high opportunity cost, absorbing excessive resources that might often be better distributed among primary, secondary and tertiary levels.¹¹

Decentralizing and regionalizing medical education and research so as to create "Academic Districts" and developing a strategy towards the provincialization of the COM are realistic long-term solutions to otherwise unyielding concentration of academic resources at Royal University Hospital. Over-emphasis on high technology and high-profile specialists and subspecialists within the COM and Royal University Hospital must be moderated by greater visibility and involvement of family physicians and other well-qualified and experienced generalists in undergraduate and postgraduate training, with increased opportunities for training, germane to practice outside of Royal University Hospital. In many respects, arguably in scaled down form,

Royal University Hospital exhibits the salient characteristics of the Academic Medical-Industrial Complex. As has been the case for such centres in the US, it appears that we may be on the cusp of major changes in the academic health sciences centres in Canada.

9.0 OTHER ISSUES

9.1 Faculty Leadership

Leadership for an enterprise the size of the COM should never rest with a single individual. Furthermore, beyond the leadership and roles of the Dean and Academic Heads, there are many other prominent leaders in both formal and informal roles. There are, of course, many different views of what represents effective leaders spanning from Machiavelli's view that effective leaders are "power wielders and individuals who employ cunning and subterfuge to achieve their own ends."¹² A somewhat more modern interpretation might be found in Max Webber's view that effective leaders have charisma, "that special spiritual power or personal quality that gives an individual influence over large numbers of people." Though some argue that management is a science, others view it as an art. The modern-day management guru, Peter Drucker, considers effective leaders "able to carry out the functions of management: planning, organizing, directing, and measuring."

As to functions and influence wielded by leaders, it is generally held that the most effective leaders have mastered the art of "getting things done through others" and are themselves change agents, not only able to enunciate a vision but able to translate that vision into action. As functioning individuals operating within a framework of humanistic psychology, William Hitt suggests that there are five leadership dimensions, which comprise 25 specific leadership competencies.

The Model Leader

REASONING	•Conceptual Skills •Logical Thinking •Creative Thinking •Holistic Thinking •Communication
COPING	•People •Information •Networks •Excellence •Integrity
KNOWING	•Knowing the Job •Knowing the Organization •Knowing the Business One Is In •Knowing the World •Knowing Oneself

BELIEVING	•Visioning •Coaching •Motivating •Team Building •Valuing
BEING	•Identity •Independence •Authenticity •Responsibility •Courage

Leadership Competencies: Thoughts on leadership, A Treasury of Quotations, by William D Hitt. Battelle Press, Columbus, Richland, 1991.¹²

The transformation of Canadian medical schools required to confront new realities, fiscal restraint and substantially altered service delivery, will require these leadership competencies. In the case of the COM, this includes the Dean and Academic Heads, to name only a few. Accordingly, these characteristics should be specifically sought in choosing academic leaders, who have traditionally been judged on the basis of academic and scholarly accomplishments. Notwithstanding the critical importance of these attributes, current-day and future Deans and Academic Heads must have leadership characteristics and competencies. While this raises the age-old question as to whether or not such leaders are born or made, the reality is, it is some of both. The point remains that the UofS and the COM must include these characteristics in search and selection processes, and look for either educational attainments which lead to these competencies, or practical experience that has come from the requirement to exercise these skills. Preferably, the choice of future faculty leadership should attempt to identify incumbents with both elements.

9.2 Vision, Mission, Values

There is a frequently stated maxim that says "if you do not know where you are going, any road will take you there." While management fads come and go, it remains intuitively and pragmatically obvious that an organization such as the COM must have a clearly defined Vision of the future, and an understanding and statement of Mission as to how to achieve this. The underpinnings for Vision and Mission are the fundamental values held by the COM. All too frequently, such values are not rendered explicit. Without them, governance and management process may fall victim to changeable opinions, as opposed to core beliefs.

This is a critical time for the COM to stop and take stock of its past and present and chart a course towards the future, within a widespread, iterative and transparent process to establish Vision and Mission, based on enunciated values. This is a periodic exercise required of all human organizations and is one that has simply not been undertaken by the COM. In the process of doing so, it is critically important that the social responsibilities of the COM and the alignment to Saskatoon and other Health Districts be given paramount consideration. It is in this regard that we once again reiterate the key element that aligns the Vision of the COM to Saskatoon Health District - the pursuit of health and wellness in Saskatchewan's people. While the Health District utilizes health care delivery, services and programs to achieve its ends, the

COM exploits teaching and research, as well as participating in service delivery, to achieve its ends. The means may be different, the ends are the same.

It is timely, necessary and a fundamental component of rebuilding the COM to engage in a major exercise which involves the full scope of the COM leadership, faculty, staff and students, together with other critical stakeholders, many of which are specifically connected to some aspect of this Review. Countless interviewees and respondents have lamented the absence or implicit nature of the COM's Vision which, from some perspectives, has been a long-term deficiency, described by one respondent as "the COM being a victim of multiple expectations, multiple responsibilities, multiple complexities, and yet without multiple supports." Accordingly, the COM has become "a plethora of jurisdictions of public, physicians, faculty, students, organized medicine, to name only a few." In addition, external accrediting agencies and the University place further expectations on the COM. In the end, without a clear Vision and Mission, there are critically important questions left unanswered, such as what the UofS wants to achieve by having a COM?

Recommendation:

The College of Medicine should take stock of its past and present, and chart a course towards the future, with a widespread iterative and transparent process to establish Vision and Mission, based on enunciated values. This exercise should be commenced as soon as is reasonably possible. It must be completed prior to the commencement of the next academic year (September 1999).

9.3 Social Contract: Clarifying Expectations

Following directly from the process of enunciating the Vision and Mission for the COM, flows the clarification of expectations as related to social responsibilities and the often-referred-to social contract with the Province, and its people. As we have argued in 6.1.8.1, there is an acknowledged obligation of reciprocity between the COM and members of society. However, to the detriment of the COM, the actual expectations and associated performance measurements have never been promulgated or understood. This has led to a dichotomous view, which on the one hand leaves the COM believing that it has no hope of fulfilling the progressively unrealistic expectations and social responsibility, while on the other hand creates the perception that the COM is "doing its own thing," to the exclusion of its broader social responsibilities. Without better clarification there is both misunderstanding and misperception, leading to failed expectations, and at a minimum creating an image problem for the COM.

In discussing these matters with Health Districts outside of Saskatoon and Regina, the concept of social responsibility is largely associated with physician recruitment and retention. In short, if we don't have doctors (presumably Canadian-born, Saskatchewan-trained), then the COM is not meeting its social contract. Accordingly, when Health Districts are having difficulties recruiting and retaining physicians, this leads to either implicit or explicit criticism of the COM, which may or may not be appropriate as bearing this responsibility. There should be dialogue, a thoughtful agreement and plan as to what proportion of COM graduates should stay in the Province, secondarily, how should they be distributed and, finally, what specific roles and responsibilities the COM should assume for training, fostering recruitment and sustaining

supply. While it is true that approximately 30% of practising physicians in Saskatchewan have originated from the COM, these are not evenly distributed outside of Saskatoon and Regina where few, if any, graduates are to be found in many Health Districts, which have become correspondingly dependent on foreign medical graduates.

In the development of the Vision and Mission of the COM, these issues must be faced squarely and explicitly, with an understanding derived from critical stakeholders, inside and outside the COM, and against which performance indicators are established and monitored. It is only with this undertaking that the COM will know and understand its expectations and all stakeholders will be aware of the extent to which the COM is or is not fulfilling the broader social good.

Beyond the complex area of physician recruitment and retention, an additional view of social contract is offered by rural Health Districts who believe the COM should act as a resource for physician upgrade and remediation programs. These will be discussed in Section 9.7.1.

Recommendation:

A clear understanding must be developed with respect to fulfilling the social contract and responsibilities of the College of Medicine to the Province of Saskatchewan. This should include, but not be limited to, meaningful involvement in the continuing and dynamic development of physician manpower plans for the Province, as well as commitments and approaches to physician recruitment and retention. Such understanding in regards to the social contract should include explicit performance indicators, and targets for recruitment of undergraduate- and post-graduate trainees upon completion of their programs.

9.4 College of Medicine as a Provincial Resource

9.4.1 Physician Upgrade and Remediation Programs

A common theme heard from the Health Districts, one which they felt is fundamental to recruitment and retention, is the need for a resource to Health Districts and their physicians' organizations, which provides a variety of programs to support academic fulfilment, upgrade and remediation. Continuing medical education will be discussed under Section 9.4.2. Beyond this, we feel that there is substantial need for physician upgrade and remediation programs and support, yet, there is no current program for these. The COM is ideally positioned and suited to expand in this area, as a contribution to broader social responsibilities.

We have heard the need for assistance in peer review processes and quality improvement programs for clinical practice. Furthermore, current physicians wish to upgrade skills and knowledge and have opportunities to do so, both in a distance learning mode and through direct involvement in clinical practice. Having physicians involved, accessing and engaging in such upgrades would contribute to retention, as well as greater career fulfilment in rural practice. Upgrades may strengthen local service delivery by bringing in or enhancing various skills and clinical practice, such as may come, for instance, from family physicians doing periods in areas

such as neonatology, anesthesia, etc. Programs aimed at upgrading physician competencies, linked together with an effective provincial approach to continuing medical education, are interdependent strategies for strengthening the knowledge and evidence-base of physicians. We argue accordingly that this strengthens retention.

Beyond upgrade programs, some physicians develop difficulties in practice, encounter stresses, physical illness or, worse still, fall victim to suboptimal or clinically unacceptable practice. Beyond the disciplinary requirements of the CPSS, there is a need for remediation which includes assessment of physician performance, individualized solutions, various forms of remedial activities and training, and assistance for re-entry to practice. These supports are becoming progressively available in other universities and require thoughtful and supportive interaction of experts in the social and behavioral sciences, together with solid evaluation and psychometric skills, supports and research.

In our discussion with family physicians, and particularly the faculty in family medicine, we are led to believe that the Department of Family Medicine is the ideal lead Department, though in suggesting the same, we do not believe that exclusive responsibility should rest there. In fact, we believe this should become a component of the responsibility for the Associate Dean, Education, given that we argue later that continuing medical education should be housed there, in conjunction with undergraduate and postgraduate programming. To undertake this task, it will be necessary to better understand the needs of Health Districts and their physicians and to have a thoughtful and collaborative approach to engaging carrying out these opportunities.

Upgrade and remediation programs will only occur if further resources are used to strengthen continuing education and the Department of Family Medicine. We would urge serious consideration of such developments, early in the tenure of a newly-appointed Associate Dean, Education. One possible approach would be the establishment of a goal-oriented task force to examine the need, and design the approach and processes intrinsic to such developments. There is much to be learned from other universities and medical schools in this regard. It would be a useful consideration to receive advice from other centres such as Manitoba and University of Alberta.

Recommendation:

We recommend that the College of Medicine, in consultation with the College of Physicians and Surgeons of Saskatchewan, establish physician upgrade and remediation programs which should be linked to the office of Continuing Medical Education and report to the Associate Dean Education. We believe that the Department of Family Medicine should take the lead and be resourced to develop a program of physician assessment and competency review, together with remediation programs and support, knowledge and skills upgrade, assessment for practice re-entry and programs of reintegration. In addition, we believe that the College of Medicine is particularly well suited to assist other Health Districts in peer review and quality improvement processes for physicians. In order to accomplish this recommendation, we urge the College of Medicine to better understand the needs of Health Districts and their physicians and to develop a thoughtful and collaborative approach to engaging and carrying out these opportunities.

9.4.2 Research Funding

This Review was not meant to undertake and has not done a comprehensive analysis of research funding, other than the detailed financial analysis of the Research Fund, as is found in Section 7.4.6.2.

Elsewhere, we have discussed mechanisms to potentially improve the thrust of health services research and the success in grant review processes. However, we would additionally make the observation that it is important that the Province of Saskatchewan must provide adequate and stable funding for health research to compliment funds that are otherwise available, usually through competitive granting councils at a national level.

It is clearly the case that more and innovative sources of research funding are becoming available through such opportunities as the Health Transition Fund, Health Information Support Program, Canadian Foundation for Innovation, and Canadian Health Services Research Foundation, to name only a few of the additional opportunities beyond the standard tri-council granting agencies. Provinces such as Alberta have additional advantages such as come from the Alberta Heritage Foundation for Medical Research. Saskatchewan is well positioned to be a key stakeholder in certain health research and has to stay competitive. Saskatchewan uses the Health Services Utilization Research Commission (HSURC) , to a certain extent, as the province's granting agency. HSURC is well respected in Canada for its solid, policy-relevant, applied research. For some time, HSURC has made the case that sufficient and stable research funding is critical to the Province, with a corresponding beneficial effect on the COM.

Increased research funding is essential to sustaining and developing any kind of credible health research activity in the Province and at the Universities. Accordingly, HSURC has requested increases in its annual grants and award expenditures from \$1.25 million to \$6.25 million. If such commitments were made, the corresponding effect on the COM's academic activity and scholarly productivity would be substantial.

Strengthening the research funding base for the Province and COM is critical to strengthening the COM and the universities themselves. We cannot emphasize enough that research must, in harmony with education in the Health Sciences, form the fundamental basis for information generation and knowledge production and refinement, as critical elements and determinants of evidence-based decision making in health and health care.

Reduced funding has put enormous pressure on faculty members, and frequently research efforts are compromised. Recruitment of top academic researchers is a major issue for most medical schools in Canada, particularly as the medical research community becomes increasingly mobile. Because of the importance of research to the academic and financial viability of the academic health science centres, new models are needed for creating collective ownership of the research endeavors by all members of the faculty. The blurring of lines between the basic and clinical research that has occurred over the past two decades allows for dynamic interactions between clinical and laboratory scientists. Stiller and Dirks (1993) suggest that developing research centers or institutes of excellence at Canadian universities is a critical element to success.¹³ The creation of these institutes is a reflection of a worldwide phenomenon of thematic and collaborative research.

These authors note that approximately 60% of MRC funding goes to institutes of research associated with academic health science centers, and further, that growth in the research budget will increasingly come from non-governmental sources. Faculties will need to respond by grouping their scientists in thematic research, in contiguous laboratories with strong ties to clinical trial capacities and with well-established policies for technology transfer.¹³

At present, UofS's COM ranks 15 of 16 in research funding accorded to Canadian medical schools. We have argued elsewhere that the Associate Dean of Research should be full-time and faculty-funded. This is critical to strengthening the research quality and quantity of output in the COM. At present, there is no internal grant review process used to strengthen applications. It has been well demonstrated in other Canadian universities that an internal review process significantly increases the acceptance rate by granting councils and the peer review process.

There is a substantial, additional argument that health sciences research organization and funding could be bolstered by joining forces across the Health Science Colleges, so as to offer greater infrastructure support to researchers. This will be discussed in subsequent sections.

9.4.3 Continuing Medical Education

Most Canadian medical schools have taken to reorganizing their continuing medical education (CME) entities so as to place them on what is believed to be a sounder business basis. In essence, it has become common practice for CME to operate on a cost-recovery basis, with the expectation that the programs offered will pay for themselves. The business logic is intuitive. The educational and academic realities are perhaps less apparent. Arguably, there is now more of a steering effect on the CME agenda brought about by programs that have the ability or willingness to pay costs, usually with enhancements for CME operating dollars. What follows is potentially lesser commitment to highly-specialized programs that may have a strong educational purpose and value, yet cannot secure a sufficient revenue base or cost containment so as to operate. We are not in a position to assess the impact that these changes have had specifically on the CME programs of the COM. But, we suggest that it is not negligible and to the extent that it exists, has to be more seriously addressed by the COM. The implications are considerable, particularly the steering effect of pharmaceutical manufacturers and other for-profit elements in the health care industry. Such influence must be understood and contained, so as to ensure that CME has the integrity found in quality programs associated with necessary and valued content, not necessarily the content that the payer believes is necessary to disseminate.

We have traced the checkered past of CME in Saskatchewan and have found that historically the hosting and sponsorship has been fragile. CME needs to be strengthened and more properly aligned to the COM, taking into account the interest of the province's physicians and the valuable input from SMA. The SMA has participated in sustaining CME, but would do well to reconsider its level of investment in it and, to the extent possible, offer a higher level of financial support as a strategic investment in the interests of its physician members. The greater the extent to which this is done, the greater the extent that programming should reflect the interests of the physicians in the Province, as represented by SMA. Proactive academic

marketing and survey analysis to determine the needs and wants of Saskatchewan's physicians should be critically important routine requirements for operating CME programs.

As we have suggested, it makes sense to align CME to the Associate Dean Education and jointly manage educational programs that span the continuum from undergraduate to postgraduate, and finally practising physicians. While graduate training programs or advanced degrees could be linked here, we have suggested elsewhere this is better positioned and directly aligned to the Associate Dean of Research, given the thesis and research orientation of most graduate degrees.

As to the program and agenda for CME, the entire label - continuing medical education - is constraining to the extent that one defines "medical education" as being about clinical medicine. The CME programs directed at physicians must become far more diverse, encompassing a spectrum of interests that not only include clinical medicine and practice but, as well, policy-relevant or broader health sciences topics and content. Most notably amongst this would be the valuable addition of health services management education directed at physicians, particularly those that aspire to broader roles in physician administration.

More so than ever, Health Districts, governmental and non-governmental organizations are in need of physician involvement and consultative expertise which carries with it a broader understanding of the health system, management and organizational constructs and behavior. It should be a responsibility of the COM to develop and inculcate these skills as an investment for the future, intended to not only strengthen the quality of Saskatchewan's physicians, but as well, to improve the management of the system. There are already well-demonstrated high-quality and recognized undergraduate training programs in health administration within the Faculty of Commerce (we understand the University of Regina is commencing a program in Health Sciences administration). Building on and extending from this expertise, management education for physicians should be developed in concert with clinical education programs to strengthen practice. All of this would do well to find a home, in whole or part, within CME, aligned to the Associate Dean of Education, COM.

Recommendation:

Continuing Medical Education should be reassessed from the perspective of the impact of financial organization and cost recovery on program and content delivery. In addition, continuing medical education should be aligned and report to the Associate Dean Education. Further, we suggest that Saskatchewan Medical Association reconsider its level of financial support, as a strategic investment in the interests of its physician members. Accordingly, Saskatchewan Medical Association should have a meaningful involvement in the design, direction and content of continuing medical education programs. Further, we recommend that continuing medical education programs broaden their scope to include expertise in management education for physicians, as a means of supplementing clinical education programs designed to strengthen practice.

9.4.4 Libraries and Knowledge Resources

While not directly related to this Terms of Reference and from a limited perspective, we examined the knowledge resources available to the COM. The Health Sciences Library is a central component of this knowledge resource. Available comparisons from 12 other medical schools in Canada demonstrate that the Health Sciences Library has substantially fewer resources in terms of staff, space, and acquisitions budget, operating at 30-50% of the comparative resources of other schools. The estimated cost to deal with these resource deficiencies is not insignificant. The increase believed to be required for the collection budget, in order to meet current and perceived needs of researchers and clinicians from the three Health Sciences Colleges is \$500,000.

It is recognized that the responsibility for libraries rests with the UofS Department of Post-secondary Education. Unquestionably, libraries are experiencing substantial new requirements and exploding demand to respond to this new age of health information and requirements to support innovations in medical education and research, and evidence-based decision making.

We raise this because it is unreasonable to expect the COM and the Health Sciences Colleges to muster the resources and efforts necessary to deal with what is considered a significantly under-resourced knowledge base. We must caution in that we have not done a detailed analysis of costs and benefits of library activities in Saskatoon. Nonetheless, we are concerned about under-resourcing in Saskatoon. Correspondingly, we have been impressed that in the 1997/98 fiscal year, the Regina Health District attempted to deal with such problems by budgeting \$692,000 for library services which will, no doubt, have enormous value.

It would appear as if there should be a serious examination of these resources at the UofS and, accordingly, we would suggest that the COM, UofS, Saskatoon Health District, and Department of Post-secondary Education commence a task force to look at knowledge resources, including but not limited to, the UofS's Health Sciences library, but also other creative opportunities to act as a provincial knowledge resource, with meaningful ties to Saskatchewan Health and to SHIN.

The Health Sciences library and other knowledge resources must be seen as overarching, supportive elements of the academic enterprise. Regrettably, these are often forgotten in the high level of public visibility and attention seemingly accorded to salaries and other human resource issues.

Recommendation:

We recommend that the College of Medicine, University of Saskatchewan, Saskatoon Health District, and Department of Post-secondary Education commence a task force to look at knowledge-resources, including but not limited to, the University of Saskatchewan's Health Sciences library, but also other creative opportunities to act as a provincial knowledge resource, with meaningful ties to Saskatchewan Health and to Saskatchewan Health Information Network.

9.4.5 Telehealth

Though not directly germane to the Review, it seems appropriate to raise the issue of exploiting Telehealth as a mechanism of offering not only educational programming but, more specifically, delivery of health services to rural and remote regions. To the extent that the COM is involved with this, and we are of the view that the COM should be centrally involved, a Telehealth network in Saskatchewan would offer an additional contribution for the COM to fulfill its social contract. Given that there is highly concentrated specialty and tertiary services within the COM and its faculty, it is reasonable to assume that the COM could be a major purveyor of consultative expertise and, as well, CME opportunities.

The timing for expending interests to include Telehealth is particularly apt, given developments with the Saskatchewan Health Information Network (SHIN). As SHIN develops an integrated, networked capacity for health information in the Province, telehealth can be developed in an integrated and parallel fashion to achieve both service delivery and educational objectives.

10.0 BEYOND TRADITIONAL ORGANIZATION STRUCTURE: SHAPING THE BLUEPRINT

Much of what we have suggested and recommended deals with the roles and relationships of the COM and addresses the internal management and organizational structure, as well as the linkage to key "external" stakeholders, such as the Saskatoon Health District, Saskatchewan Health and so forth. Within the terms of this Review, we might otherwise limit our perspective and advice to this degree. However, through the input of many, we are compelled to address the strong view which asserts that major structural and organizational changes are necessary. Furthermore, we sense that the environment is potentially more receptive to fundamental change than perhaps it has been. Accordingly, we believe that there is substantial merit in considerations beyond traditional organizational structures. We recommend that the work and analysis of this Report lead to progressive and responsible steps, as outlined in Section 11. The ideal objective would be to establish cross-sectoral, financial and academic economies, through an approach to three separate but linked considerations, namely the establishment of a Sub-Board for Health Sciences at the UofS, the formulation of the position of Vice-President Health Sciences, and later Vice-President and Executive Dean Health Sciences, and ultimately, merger of Health Sciences. These will be discussed respectively.

10.1 Health Sciences Governance

Establishing the position of Vice-President of Health Sciences, as discussed in 10.2, is a critical linkage in restructuring the senior management for the COM. But, to be fully effective, this has to be further and structurally linked to the Board of Governors of the University. We have reviewed the logic of the Kerr White Report in this regard, which called for the establishment of a board structure for the COM. For many pragmatic reasons, this did not occur and, in retrospect, it is perhaps questionable as to whether or not it should have been created. Creating individual and separate governance for components of the University, particularly if not inextricably linked to the existing governance structure and processes, cannot work. Nonetheless, it was and remains correct to tighten the linkage and close the gap between the Board of Governors and the COM. To do so, we recommend the establishment of a sub-Board

for the COM. We will address further developments and suggestions for the sub-Board under Section 11.4.

We have proposed that all funding, budget formulation and approval, and financial reporting be consolidated and contained within the UofS. Following from this, there would be comprehensive reporting, approvals and, overall, financial accountability and understanding. It is true, however, that the UofS has not typically taken an interest in and may not feel well positioned to become involved with a health services delivery system, and beyond this the broader social responsibilities of COM. We urge that the UofS seriously consider this position and, more completely incorporate the COM as an integral component to the Health Sciences, but with special needs and requirements for governance, which prompt innovative solutions. In this case, we suggest governance should be in the form of a Board committee or sub-Board for Health Sciences. Most suitably structured, we would suggest four existing members of the Board of Governors from the UofS, joining the Deputy Minister of Health, CEO of Saskatoon Health District, Dean of Medicine and Vice-President of Health Sciences to formulate this sub-Board for the COM. This would complete the linkage to the governance process and, of course, provide more direct yet strategic advice closer to where it is needed, yet contextually aligned with the broader strategies and perspective of the University's Board. Membership alone would foster this. However, within the usual and appropriate processes for Board committees, the so-called "final say" would continue to rest with the Board of Governors. Pragmatically and appropriately operated, the Board committee or sub-Board obviates any need for high-level detail considerations by the Board while, nonetheless, permitting an opportunity for governance and accountability to be fully discharged through an intermediary mechanism that effectively links the UofS to the COM and, secondarily, to the health delivery system, as represented by the Saskatoon Health District and Saskatchewan Health. Arguably, others could be added to this Board. Operationally, it would be wise to limit its size and maintain a strong alignment to the parent Board. It is generally held that the ideal Board size is 9-12 persons.

We recognize that there is no or limited experience with using "external" members to populate Board committees. This might well test the resolve and regulatory structure of the UofS in order to accomplish this. The fact remains that this would be a unique but intermediate governance structure and the representation to it should be as inclusive as is reasonable and possible, so as to create a milieu and willingness to provide effective governance. This is clearly a logical step that could take place in close association with the development and implementation of the position of Vice-President of Health Sciences.

As discussed earlier, we have examined several models of governance and management, mostly found in the US. Beyond these we turn to two examples that lend guidance to our thinking. The Canadian example, McMaster University has merged the Health Sciences and created a position of Vice-President and Dean of Health Sciences. As has been and is the case, the Dean of Health Sciences is the Dean of Medicine. We have not reviewed or analyzed documentation of McMaster's structure, function, and success. Nonetheless, we would suggest that McMaster is internationally known for its quality of medical education and research and, furthermore, McMaster has made great strides in differentiating its academic and scholarly capabilities both at home and abroad. Accordingly, we would conclude that there is at least one Canadian example where consolidated senior management of the Health Sciences is operational, and at least, as it relates to the attributes to the medical school at McMaster, has

resulted in international academic recognition.

There are no other such examples in Canada of which we are properly aware but we have investigated further the Office of Executive Dean of Health Sciences at the University of Queensland, Australia. The broader organizational structure at the University of Queensland is sufficiently at variance with the UofS to constraint the applicability of this analogy. Nonetheless, the organizational chart from 1997 is enclosed. In this case, the Executive Dean for Health Sciences, reports directly to the Pro-Vice-Chancellor. We have suggested that the Vice-President of Health Sciences report directly to the President.

The Executive Dean of Health Sciences, University of Queensland, is the Senior Administrator of the School of Medicine, School of Pharmacy, School of Dentistry, and School of Rehabilitation Sciences which includes physiotherapy, occupation therapy, speech therapy and audiology. We gather that a new Department in Human Movement Studies has been recently added and amalgamated to the School of Rehabilitation Sciences. The Head of each of these schools, plus the Chair of Research, Chair of Education and Learning form the Faculty Executive Committee, led by the Executive Dean of Health Sciences. In discussion with the current incumbent, Professor Brooks, he has indicated that this is a particularly strong organizational structure in terms of permitting the facilitation of change across the Health Science disciplines at that University. From this position, there is currently a major reorganization of the Graduate School of Medicine, away from departments to disciplines, with concentration of power remaining with the Head of each School. The University of Queensland similarly has consolidated accounting procedures and financial management. What is most important is that the Executive Dean of Health Sciences is a member of, what Professor Peter Brooks refers to as, "the inner cabinet of the University." In his informal advice to us, he commented that he thought that this was an ideal organizational structure that might well work, given his understanding of the Canadian system. But, he suggested, in addition, that it was particularly critical that from this position there be brokering and very close linkage with the Health District(s).

Suggesting a merger of the Health Sciences is not offered lightly. The magnitude and significance of this change is daunting. We believe for this step to be successful, there would have to be far more strategic, thoughtful planning to develop the business and academic case for such an undertaking. Accordingly, we are not recommending this as an automatic recommendation but, rather, as a serious suggestion to consider as a continuation of major restructuring which must commence within the COM and occur in a sequential fashion as we suggest in Section 11. The process of considering the potential for merger of Health Sciences raises issues and sensitivities for the other Colleges which, of course, must be thoroughly investigated. While it is easy to make the argument for this merger on behalf of the COM, it may not be as robust or appropriate an argument for the other Health Sciences. We have not been charged with the responsibility of or given the opportunity to examine the financial and organizational characteristics of the other Health Sciences, so as to ensure that this recommendation is sufficiently robust and that the environment and responsiveness is sufficiently established to ensure success in implementation.

Be that as it may, we believe work should commence on this strategic thinking, forthwith. Much of this can be done internally and need not depend on external consultants or unnecessarily large quantities of advice from elsewhere. If the merger of Health Sciences is, however, given

serious consideration, we would urge that several cross-cutting functions be established within the office of the Vice-President of Health Sciences. These would include a high-level, well-trained and accomplished business-oriented Chief Operating Officer for the Health Sciences, around which would be consolidated the business and financial infrastructure in each of the respective disciplines. Furthermore, we would recommend replacing the proposed Associate Dean of Research, COM with the eventual establishment of the Associate V-P Health Sciences Research, with dual reporting relationships to the V-P Health Sciences and the V-P Research, UofS. The Associate V-P Research for the Health Sciences should take charge of establishing or continuing an effective, interdisciplinary graduate training program across the Health Sciences, as well as formulating and implementing an effective internal grant review process to improve success rates with national granting agencies.

Our additional and final thoughts on this subject may be found in Section 11.7, as is our thinking on the logical road-map for the incremental steps to progress.

10.2 Health Sciences Executive Management

Progressively more these days, medical schools within their respective universities are finding opportunities and relevance in greater association with the other health sciences. By-and-large to this point, health sciences have developed along professional lines with the creation of schools and faculties of medicine, nursing, pharmacy, dentistry, etc.. The COM at the UofS has had some experience in broadening its scope to include rehabilitation. From the input of respondents around this area, the reviewers believe that the fusion of Medicine and Rehabilitation Services has been successful and to the joint benefit of both. With these realities in mind and, further, recognizing the social responsibilities associated with medicine and the other health sciences, this raises the opportunity of repositioning the Health Sciences within the larger academic university context. This is a particularly notable issue with respect to the roles and responsibilities of the VP-Academic. The vast size and scope of these portfolios in Canadian universities, and the fact that they are managed as well as they are, is a tribute to the incumbents and their predecessors. However, there have always been and will continue into the future, to be concerns that the Health Sciences may not always be well represented at the level of the corporate Executive of their respective universities. Of course, this may be offset by the respective vice-presidents coming from a background of Health Sciences or alternatively, other mechanisms put in place to consolidate and sustain the interests of the Health Sciences, while permitting opportunities to bring their agenda, more predictably, to the corporate Executive.

At the University of British Columbia, and the University of Alberta attempts to coordinate the Health Sciences have been taking place, largely through voluntary and cooperative efforts of the health sciences Deans, and a coordination function rendered by faculty or middle management. This is not the same as more seriously considering the positioning of Health Sciences and giving them prominence and input in the University. We believe there are economies to be gained financially and academically through the creation of a Vice-President of Health Sciences which reports directly to the President of the University, and is a member of the Corporate Executive. In this model, the senior executive, current Deans of the respective Health Sciences would report to this position, and the Vice-President of Health Sciences would have overall management accountability and responsibility for all of the Health Sciences, strategically, operationally and financially. Specifically, the role would include accountability for

all aspects of academic programs, staff management, resource allocation, and representation of the faculty and the University to the wider community. As well, this high-level position would hold key responsibilities for the development of additional sources of non-governmental funding and, in parallel, represent the University to the external community, while exhibiting entrepreneurial ability to attract revenue in addition to supplemental government-based funding.

This position is meant to bridge the vast gap currently existing between the University Corporate Executive and V-P Academic's office, and the Dean of Medicine. Undertaking such an approach clearly would require reconsideration of the VP-Academic's portfolio, and redistribution of responsibilities likely across the entire University Executive. The University, in considering this approach, has to take into account the social responsibilities of the COM that extend beyond the University and its provincial orientation.

The creation of such a position would recognize the vast and varied resources coming to the Health Sciences, particularly in the area of research funding, industry and philanthropic support. Strong Health Sciences strengthen the University. A strong well-organized Corporate Executive of the University strengthens the Health Sciences. For these conditions to be met, there has to be structural linkage beyond what currently exists. Accordingly, this leads to our recommendation for creating the position of the Vice-President of Health Sciences, through which there would then be effective linkage of governance and management.

Within the scope and limitations of this Review, we are unable to examine the implications of this recommendation outside of the COM. It remains to be determined the degree of receptiveness to such an approach, though we would expect some concern and resistance, prompted by concerns of losing of losing professional identity. Furthermore, the implications of this to the broader organizational design and structure of the University and its Corporate Executive may be immense, and accordingly have to be considered in the broader context of Vision, Mission and Strategic Planning for the UofS. Of importance, therefore, despite the fact that we are unable to argue on an empiric or detailed financial grounds for the creation of the Vice-President Health Sciences, both organizationally and operationally and, based on our understandings from elsewhere in Canada and in one case Australia, there is need to seriously examine the issue of creating this position, in association with a strategy and a structure to deal with health sciences governance.

Recommendation:

We recommend that the University of Saskatchewan close the gap between the Board and the College of Medicine by establishing a sub-Board for Health Sciences.

Recommendation:

We recommend the establishment of the position of Vice-President Health Sciences as the overall management executive responsible for Health Sciences. We recommend that once the Vice-President of Health Sciences position has been established and is operational and the sub-Board for Health Sciences has been established and operational, meaningful work should commence to examine the implications, costs and benefits of merging all Health Sciences, with the endpoint of consideration being the establishment of a position of Vice-President and Executive Dean for Health Sciences.

11.0 LOGICAL AND INCREMENTAL STEPS ON THE ROAD TO PROGRESS: BUILDING FROM THE BLUEPRINT

Drawing from the body of this Report and thinking beyond traditional organizational structures, we suggest that consideration and implementation of our recommendations be undertaken in step-wise sequence. In suggesting this, we nonetheless signal caution that implementation of a reviewer's findings with such substantial and far-reaching recommendation, runs the risk of faltering after early or easily accomplished deliverables are achieved. Accordingly, the conviction to further formulating and finally implementing the recommendations must be based on a commitment to invigorating and strengthening the COM, through a highly iterative and open process commences with logical and appropriate planning, and proceeds to the establishment of structural and organizational features, finally leading to a consolidation of interests. We believe that there are economies of scale and scope to be achieved from both a financial and academic perspective.

While commitment to and success in the terminal steps of this journey are not prerequisite to success in the initial steps, the reverse is not the case. Logical and incremental steps on the road to progress must be built on a solid foundation which will come from promulgating the Vision, Mission and strategic plan for the COM. This should be complemented by engaging in effective internal and external communication processes and undertaking necessary internal management restructuring.

11.1 Vision/Mission/Strategic Planning - First Steps

As argued in several places, a clear road-map is required based on core values, which emerge from dialogue and thoughtful iteration. It should follow a series of steps and interactions that lead to the promulgation of a clear Vision for the next five years for the COM, and in tandem the formulation of a clear Mission, describing how this is to be achieved.

We have suggested that a critical component to advice on policy and overarching issues should come from the Planning and Priorities Advisory Body. But, multiple stakeholders inside and outside of the COM must be involved with this strategic process as well and give input and feedback as it occurs. This will not be a quick or simple undertaking. It will require a fusion of views and, to a certain extent, ideology. But, the end product is quite obvious and must, at a minimum, include a much clearer understanding of what is to be achieved by the COM and through what means, and to a certain extent by whom. It should take into account the social

contract and responsibilities to the Province and a much broader view as to how the COM is aligned to the health services delivery system, particularly in Saskatoon, but, as well, in Regina and elsewhere. Beyond any doubt, however, it remains that the first in the logical and incremental steps necessary is consideration and finalization of the Vision, Mission and strategic plan for the COM which, while urgently required, will require much time, energy and thought. This could reasonably be completed prior to the commencement of the next academic year (Sept, 1999).

11.2 Image/Communications (Internal, External) - A Critical Success Factor

The internal communications process of the COM requires meaningful professional attention by an individual who is committed to developing a communications strategy for the COM. The communication strategy must incorporate both internal and external communication within its purview. Communications is such a critical success factor to the COM, we believe that this has to be embodied in someone's job description and commitment. It is apparent that an individual with strong communications and public relations skills is required. Because we believe that communications and "friend-raising" is prerequisite to "fund-raising," we would suggest that these elements be combined within the job description for an Officer in Public Relations and Fund Raising, with the obvious apparent added advantages. Clearly, this will need to be resourced, as this feature and capacity does not exist at present in the COM. The incumbent must have an external profile and must be involved beyond Saskatoon, with a meaningful linkage to elsewhere in the Province, advancing the aims and objectives of the COM and acting as an additional receptor for feedback in communications coming from Health Districts and other relevant stakeholders.

Recommendation:

Recognizing effective communications as being a critical success factor, we recommend establishment of a position of Officer in Communications, Public Relations and Fund Raising.

11.3 Internal Management Restructuring

As we have argued and recommended, strengthening the future of the COM requires necessary internal management restructuring, which should take place as quickly as is reasonably possible, but must be completed by the commencement of the next academic year (Sept, 1999). This includes, to reiterate, establishment of the full-time positions for Associate Dean Research and Associate Dean Education, whilst maintaining expertise in postgraduate and undergraduate medical education through the appointment of Assistant Deans for each, with a commitment of 0.5 FTE. In addition to aligning undergraduate and postgraduate medical education, CME and physician upgrade and remediation should be included within this portfolio. Finally, and most importantly, we have suggested the establishment of a 2IC to the Dean in the form of Associate Dean of Clinical Services, who should be the representative of the COM at the Senior Leadership Team meetings of the Saskatoon Health District.

As we have recommended, the Academic Head for the respective departments should report to the Associate Dean of Clinical Services, for all matters pertaining to health service delivery, and correspondingly to the Associate Deans Research and Education, for respective requirements and reporting. The establishment of such an approach obligates the Dean to undertake measures to strengthen and render more effective the Executive Committee. It should meet weekly and adopt a problem-solving approach.

11.4 Sub-Board Establishment - Building Governance and Accountability

It is arguable as to whether or not the governance structure, or senior management changes should come first. Practically, consideration for the establishment of the sub-Board should take place as soon as is reasonably possible. In our view, this should be established by April 1, 1999. We would urge that this Board oversee the process and the success of developing the Vision and the Mission and take on the strategic governance functions associated with CSF. Furthermore, we believe that this sub-Board must be the center for financial management and accountability and, accordingly, should receive and approve the annual budget of the COM, in congruence with budget approval processes elsewhere on campus and in government. Regular financial reporting, internal financial review, and any element of internal audit should remain the purview of the sub-Board. In addition, we believe that it is appropriate to strengthen accountability through the formation of an external audit process by the Provincial Auditor's office, as we have described.

11.5 Executive Management: Vice President Health Sciences - Linking Governance Management

Establishment of Health Sciences Executive Management requires further research and analysis, examining the other Health Sciences from the perspective of benefits, risks and financial and academic economies and potential. Nonetheless, we believe this step to be a necessary ingredient to change, which is highly complementary to the establishment of the sub-Board, but certainly not a prerequisite to it. As we have argued, the sub-Board establishment is a meaningful attempt to strengthen governance and accountability, whilst the establishment of the Vice President of Health Sciences further completes the picture by linking management and governance. We recognize, however, that this is a complex step that moves to a more medium-term agenda, with the potential of establishing this position in an operational sense by April 1, 2000.

11.6 Academic Districts

With particular attention to the physician community, continuation of the two solitudes would be unproductive and potentially fatal to the COM but, as well, may be particularly damaging and threatening to the Saskatoon Health District. Accordingly, we would urge a thorough reconsideration of the Academic Medical-Industrial Complex as is embodied in the Royal University Hospital. It is logical to maintain high-end tertiary and specialty services as highly concentrated at Royal University Hospital. It is not logical to maintain the entire academic thrust from there. We do not accept arguments made by some that this is giving away to "private enterprise." On the contrary, this is strengthening the COM through proper fusion of the interests, strengths, goals and objectives of the COM with the District. It makes little sense to limit the academic enterprise to a single building. It makes every sense to recognize the

ambulatory shift and the health care restructuring implications for the COM and to allow the expertise and the educational research programs to follow accordingly. In short, it is time to regionalize the COM, understanding of course that while this principally involves integration across Saskatoon Health District, it should not limit itself to this. In addition, the Academic District must include Regina in a meaningful, well-formulated fashion, in an attempt to dispel the unrelenting, historically-based consternation associated with the presence of the COM in Regina. Solving this problem alone would quell a substantial quantity of the argument about failed social responsibility which emanates from Regina, and important stakeholders within it.

The Academic Health District may be seen as a serious threat to some private practitioners, who may wish to use every energy to resist change and avoid incumbrance brought on by, what is perceived to be, an unwieldy and highly-intrusive COM. We are not arguing for all physicians having the same relationship to the COM and Saskatoon Health District. We are, however, arguing that the role of every physician in relationship to COM and Saskatoon Health District must be defined and/or redefined. While it is true that some physicians working in Saskatoon may have little if anything to do with the COM, and correspondingly, some faculty members in the COM will have little if anything to do with Saskatoon Health District, we consider that these should be largely outliers. For the most part, all physicians should have meaningful and defined relationships which include an understanding of responsibilities, expectations and returns for such expectations by the physicians, District and the COM. We believe the SMA and the CPSS can be effective brokers and enablers of such change, but only if the collective will in the physician community and beyond is present. Forcing amalgamation will not work. If physicians cannot be convinced they will be better off, they will resist. As the Saskatoon Health District matures in its management function and its cross-sectoral management of the care continuum, there are joint interests and business opportunities which can be particularly created and would be attractive to hospital-based or hospital-dependent physicians, thereby strengthening the District and stabilizing the physician commitment within it.

11.7 Merged Health Sciences and Establish Cost-Cutting Functions (Business and Research) - Grasping the Future

To fully grasp the future, we advise establishing cross-cutting functions in the Health Sciences, elevating the quality and direction of financial management and operations through the establishment of the Chief Operating Officer for Health Sciences. As we have also argued, the establishment of the Associate Vice-President for Health Sciences Research is a logical step, though not urgent, if formative steps to establish the precursor Associate Dean, Research proceeds in the near term.

As we have suggested, merging the Health Sciences will require further analysis and thoughtful review, which will need to rise above territorialism and organizational or professional 'silos.' Merging the Health Sciences would offer substantial opportunities to create multidisciplinary curricular content, in formative years to have joint educational processes, and to rationalize infrastructure supports.

We believe that it is possible with the merging of Health Sciences and the establishment of a Vice-President of Health Sciences that this could ultimately lead to complete amalgamation and establishment of the position of V-P and Executive Dean of Health Sciences. At this point, the traditional role of Dean in the COM and other Health Sciences disciplines could be eliminated,

while strengthening the 2IC positions, and any other and appropriate positions in the respective Health Sciences disciplines. We recommend this happen in the longer term, once there has been experience with and institutionalization of the V-P, Health Sciences as a prerequisite step.

11.8 Alternate Payment Plans, Academic, Nonacademic - Finishing the Job

We have concerns that as academic resources are more widely distributed across the Districts, it will be critical to ensure that mechanisms for remunerating clinical services do not adversely affect faculty, who may find their practice opportunities and their lines of referral disrupted. CPPs which depend on fee-for-service income will not likely thrive in this distributive environment, and while we do not argue that CPPs should necessarily end, we believe that effective, alternative forms of payment for faculty could reasonably be considered. It is not a particularly innovative exercise to eliminate fee-for-service for full-time faculty. It will, however, be a challenge to ensure that there is income stability, fairness, internal equity and general satisfaction.

We do not limit our view on alternate payment plans to academics, though this is the first and foremost group that should be considered in finishing this job. While the process for and approach to gauging the potential for alternate payment plans for physicians at large, within the Saskatoon Health District appears daunting, it is not impossible. But, clearly, this is a much longer term proposition, with a time-line for consideration and potential implementation in pilot form of some to three to four years. Much is being learned elsewhere in the country in this area, and provided that academic faculty that move from existing practice arrangements are defended against serious swings of clinical practice volume and income, we feel that alternate payment plan agenda can be developed, in due course, in an iterative fashion and with meaningful input from SMA and other relevant stakeholders.

12.0 PERFORMANCE INDICATORS

The assessment of performance in the College of Medicine is essential for effective management, decision-making, and strategy formulation. As schools of medicine look for ways to ensure their efficient operation under fixed or diminishing resources and increasing public scrutiny, performance measures are useful to identify distinct areas for celebrating achievement or requiring change. The development and validation of a performance assessment framework can be used by medical schools to evaluate and continuously improve performance, identify areas of unmet need, mobilize resources for improvement, as well as provide for greater accountability.

Although organizational scholars and practitioners have long been interested in the concept of organizational effectiveness, to date no single model of organizational performance has been established or adopted. Compounding its difficulty in application and organizational effectiveness is a multi-dimensional concept that is specific to the individual organization as well as the situation. In addition, performance in social systems, including schools of medicine, have outcomes that cannot always be precisely measured.

Nevertheless, the management of performance requires the establishment of valid and reliable performance indicators. A performance indicator can be used to measure structure, process, or outcome. As a measurement tool, they can be used to monitor, evaluate, and improve organizational functions. Although we tend to think of performance measures as being quantitative

and objective, they can also be useful even when they are qualitative and subjective in nature. Performance indicators are thus evaluative, results-oriented, and serve as a reference point so that earlier performance can be compared to present performance. They are also useful because they help focus the efforts of organizational members on those things which the organization values. That is to say, "what gets measured, gets done." They are also useful because they provide a framework for motivating and rewarding organizational actors and other stakeholders.

Performance indicators, when developed, tested, and validated, can be used by a school of medicine to improve organizational effectiveness, ensure accountability, monitor the quality of its management, and foster collaboration with key stakeholders. Performance indicators can be used by the COM to assist in improving operational effectiveness through the practice of developing optimal performance standards and through the application of benchmarking. The COM has the potential to actively benchmark with other schools of medicine, other colleges, faculties, and universities, as well as organizations in other industries, to find suitable and progressive measures of performance.

Internal benchmarking focuses on best practices within the COM, competitive benchmarking enables the College to learn from other schools of medicine, while functional benchmarking encourages the medical school to look outside to other organizations for effective practices. Performance indicators that specifically benchmark structure, process, and outcomes can be used to monitor COM performance and assist the College in becoming more effective by focusing its efforts on finding and emulating "best practices", wherever they might be found, so as to identify areas that require future improvements. Performance measures adopted and used by the COM should focus on three areas that are consistent with its mission: medical education, research, and service. Regardless of which indicators are developed and used, the standard for choosing indicators for monitoring and evaluating COM performance must be done with the implicit purpose of providing the COM with a means to improve the health status of the population of Saskatchewan.

In recent years, there has been a great deal of interest in the development and promulgation means and mechanisms, for improving the public accountability in health care organizations. The movement for "value-for-money in the public sector" suggests that health, education and social service organizations must be made accountable for the money provided in terms of securing desired, socially legitimate outcomes. Many health care organizations and systems are developing and using report cards as a means of increasing their accountability with the general public and with governments and others relevant constituencies. Although the COM produces a number of audited and non-audited reports for a host of stakeholders, including performance summary reports that are required by those whom accredit it, there has not yet been developed a consolidated and integrated report card that can be used in a systematic, periodic, and routine basis. By using a validated and reliable performance report card, publicly promulgated on an annual basis, government and the general public can better monitor and evaluate the progress that the COM is making in achieving its educational, research, and service missions.

Using performance indicators and report cards can provide a mechanism and means by which the COM can achieve a broader accountability and social legitimacy for its diverse missions. When one speaks of accountability, it is necessary to identify four types of accountability that the COM needs to secure: political, customer, commercial, and community.¹⁴ Political accountability for the COM refers to its ability to respond to externally imposed mandates that are provided by

government funders. Customer accountability refers to the level of acceptability and satisfaction that its services (ie. education and clinical) provide its students, clients, or patients. Commercial accountability focuses on creating value for the marketplace. Research conducted in a medical school deals with finding and developing medical products or devices whose ultimate aim is to advance the health status of society. Community accountability represents the public trust and necessarily reflects the interests and concerns of the citizens of Saskatchewan. In order to be truly meaningful, any report cards produced and used by the COM should necessarily track a variety of relevant performance indicators that enhance political, customer, commercial, and community accountability.

In securing accountability broadly for the COM, valid and reliable performance indicators can also be used to monitor the performance of College management, as well as permitting management to guide internal decision-making processes and resource allocation decisions. Many progressive organizations in the public and private sectors are now using balanced scorecards as a means of securing valued strategic objectives and aligning their mission to everyday organizational processes. A balanced scorecard provides management executives with a comprehensive framework that helps translate the organization's strategic and tactical objectives into a coherent set of performance measures. Balanced scorecards, first developed by Kaplan and Norton of the Harvard Business School, use assessment measures that take a more balanced perspective on organizational performance (beyond the traditional over-reliance on economic performance), by identifying four broad areas of system performance: financial measures, customer measures, internal process measures, and organizational growth/development and adaptation measures. They are now gaining in popular use by a number of health care organizations in Canada.^{15,16} By using a balanced scorecard approach, the management of the COM will be better able to translate and operationalize its general mission statement into concrete factors that really matter to its key stakeholders and will increase its level of accountability, while providing an internal mechanism which will support the creation of an annual report card that captures its progress in attaining its missions.

It is also suggested that the management of the COM consider the use of Hoshin Planning (also called policy deployment)¹⁷, in tandem with the use of balanced scorecards, as a formal means of aligning organizational action with its articulated mission statement. First developed and promulgated in Japan, many organizations in private and public sector organizations in North America are now implementing Hoshin Planning as a means of securing greater alignment with its stated mission.

Routinely collected and promulgated performance indicators can also be used by the COM to facilitate cooperation and collaboration with its relevant stakeholders. Because of the interdependent nature of much of the activities undertaken by the COM, and because progress on achieving its mission necessitates close collaboration with its key stakeholders, it is imperative that the College work closely with these stakeholders in developing performance indicators.

We recommend that the College of Medicine develop performance measures to be used for management and governance purposes. When contemplating which performance indicators should be routinely collected, the COM should consider the following:

1. Only valid and reliable performance indicators should be used;
2. All performance indicators used should be linked to the overall strategic plan of the COM;

3. Diversified input from its key stakeholders should be sought before determining which performance indicators to use;
4. Efforts should be made to ensure that the quality of the data that is used in measuring performance is of sufficiently high quality, and;
5. Performance indicators that are used should have both strategic and operational utility.

Recommendation:

In order to increase the accountability of the College of Medicine, it is recommended that the College of Medicine, after consultation with its key stakeholders, create, test and use a balanced scorecard or performance indicators. The balanced scorecard developed will include financial, customer, internal process, and employee measures of performance. It is also recommended that the College of Medicine more explicitly and formally align its diverse missions to its day-to-day management activities and processes.

Recommendation:

In order to increase the accountability of the College of Medicine with government and the public, after extensive consultation with its key stakeholders and funders, it is recommended that the College produce and promulgate an annual community report card that identifies and tracks relevant and valued performance indicators. The report card should include stable indicators that address measurable performances in education, research and service achievements.

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THE UNIVERSITY OF SASKATCHEWAN
College of Medicine
Statement of Operations and Fund Balance by Fund
For the Year Ended April 30, 1997
Unaudited

Appendix 1 (a)

	Unrestricted Funds				Restricted Funds			Endow - ment	Grand Total All Funds
	Operating	Clinical Services	Clinical Practice Plan	Other Specific Purpose	Total Specific Purpose	Trust	Research		
Revenues									
University operating budget	14,960,671								14,960,671
Government grants and contracts									
Government of Canada				1,296,573	1,296,573		2,737,886		4,034,459
Province of Saskatchewan		16,104,345	3,583	3,630,595	19,738,523		2,264,454		22,002,977
Other				258,741	258,741		69,900		328,641
Student Fees									
Gifts, grants and bequests			97,117	1,722,847	1,819,964	96,377	5,247,523	94,542	7,258,406
Sales of services and products	52,765	123,560	12,957,557	915,441	13,996,558	635,561	6,105		14,055,428
Income from Investments						99,458	12,172		635,561
Miscellaneous Income				119	119				111,749
	15,013,436	16,227,905	13,058,257	7,824,316	37,110,478	831,396	10,338,040	94,542	63,387,892
Expenses									
Salaries									
Academic	9,991,913	4,468,206	8,061,640	1,703,598	14,233,444		194,271		24,419,628
Other	2,348,031	7,632,454	2,786,547	5,273,427	15,692,428	1,500	6,394,162		24,436,121
Employee Benefits	1,547,061	918,395	866,106	475,232	2,259,733		516,239		4,323,033
Salaries and benefits	13,887,005	13,019,055	11,714,293	7,452,257	32,185,605	1,500	7,104,672	0	53,178,782
Non - salary expenses	1,025,622	(38,059)	4,393,162	1,240,303	5,595,406	587,807	2,987,918	0	10,196,753
	14,912,627	12,980,996	16,107,455	8,692,560	37,781,011	589,307	10,092,590	0	63,375,535
Net revenues (expenses)	100,809	3,246,909	(3,049,198)	(868,244)	(670,533)	242,089	245,450	94,542	12,357
Interfund transfers		(2,672,453)	2,555,859	116,594	0	(80,000)		80,533	533
Contingency account adjustments	75,828								75,828
Net increase (decrease) in fund balances	176,637	574,456	(493,339)	(751,650)	(670,533)	162,089	245,450	175,075	88,718
Fund balances, beginning of year	975,536	481,821	153,517	8,679,071	9,314,409	4,937,288	6,332,997	3,771,782	25,332,012
Fund balances, end of year	1,152,173	1,056,277	(339,822)	7,927,421	8,643,876	5,099,377	5,578,447	3,946,857	25,420,730

THE UNIVERSITY OF SASKATCHEWAN

College of Medicine

Statement of Operations and Fund Balance by Fund

For the Year Ended April 30, 1998

Unaudited

Appendix 1 (b)

	Unrestricted		Restricted Funds		Endow - ment	Grand Total All Funds
	Operating	Specific Purpose	Trust	Research		
Revenues						
University operating budget	15,411,346					15,411,346
Government grants and contracts						
Government of Canada		1,309,531		2,500,034		3,809,565
Province of Saskatchewan	17,431,515	34,370		2,985,730		25,448,993
Other		127,562		111,338		238,900
Student Fees						
Gifts, grants and bequests		496,945	286,604	5,141,271	116,838	8,434,733
Sales of services and products		2,393,075		2,534		15,154,286
Income from investments	103,069	1,068,217	2,548,720			2,557,065
Miscellaneous income		8,345	70,569	46,292		116,986
	15,411,346	41,950,598	2,905,893	10,787,199	116,838	71,171,874
EXPENSES						
Salaries						
Academic	10,471,779	8,730,429		365,940		26,647,618
Other	2,394,426	3,234,800	450	6,094,650		25,604,964
Employee Benefits	1,490,718	842,935		490,324		4,300,500
Salaries and benefits	14,356,923	12,808,164	450	6,950,914	0	56,553,082
Non - salary expenses	987,125	4,167,720	653,311	3,804,252	0	11,961,425
	15,344,048	16,975,884	653,761	10,755,166	0	68,514,507
Net revenues (expenses)	67,298	189,066	2,252,132	32,033	116,838	2,657,367
Interfund transfers	(17,595)	0	(2,977,484)		2,977,487	(17,592)
Contingency account adjustments	174,978					174,978
Net increase (decrease) in fund balances	224,681	189,066	(725,352)	32,033	3,094,325	2,814,753
Fund balances, beginning of year	1,152,173	8,643,876	5,099,377	6,578,447	3,946,857	25,420,730
Fund balances, end of year	1,376,854	8,832,942	4,374,025	6,610,480	7,041,182	28,235,483

THE UNIVERSITY OF SASKATCHEWAN

College of Medicine

Statement of Operations and Fund Balance by Fund

For the Year Ended April 30, 1999

Unaudited

Appendix 1 (c)

	Operating	Unrestricted Funds				Restricted Funds			Endow - ment	Grand Total All Funds
		Clinical Services	Clinical Practice Plan	Other Specific Purpose	Total Specific Purpose	Trust	Research			
REVENUES	16,371,489									
University operating budget										16,371,489
Government grants and contracts										
Government of Canada				1,309,531	1,309,531		2,500,034			3,809,565
Province of Saskatchewan				4,997,378	23,383,976		2,985,730			26,369,706
Other		18,386,598		127,562	127,562		111,338			238,900
Student Fees										
Gifts, grants and bequests				2,393,075	2,393,075	286,604	5,141,271		116,838	7,937,788
Sales of services and products							2,534			15,166,208
Income from investments			14,095,457	1,068,217	15,163,674	635,561				643,906
Miscellaneous Income				8,345	8,345	70,569	46,292			116,986
				125	125					
	16,371,489	18,386,598	14,095,457	9,904,233	42,386,288	992,734	10,787,199		116,838	70,654,548
EXPENSES										
Salaries										
Academic	11,261,766	5,835,573	10,251,136	1,099,719	17,186,428		189,500			28,637,694
Other	2,452,816	8,589,201	2,660,509	6,167,288	17,416,998	450	6,094,650			25,964,914
Employee Benefits	1,850,306	995,774	1,030,587	572,029	2,598,390		490,324			4,939,020
Salaries and benefits	15,564,888	15,420,548	13,942,232	7,839,036	37,201,816	450	6,774,474		0	59,541,628
Non - salary expenses	806,601	896,782	2,897,412	2,181,791	5,975,985	653,311	3,804,252		0	11,240,149
	16,371,489	16,317,330	16,839,644	10,020,827	43,177,801	653,761	10,578,726		0	70,781,777
Net revenues (expenses)	0	2,069,268	(2,744,187)	(116,594)	(791,513)	338,973	208,473		116,838	(127,229)
Interfund transfers		(3,273,094)	3,156,501	116,594						1
Contingency account adjustments										0
Net increase (decrease) in fund balances	0	(1,203,826)	412,314	0	(791,512)	338,973	208,473		116,838	(127,228)
Fund balances, beginning of year	1,376,854	293,601	(285,122)	8,824,463	8,832,942	4,374,025	6,610,480		7,041,182	28,235,483
Fund balances, end of year	1,376,854	(910,225)	127,192	8,824,463	8,041,430	4,712,998	6,818,953		7,158,020	28,108,255

THE UNIVERSITY OF SASKATCHEWAN
College of Medicine
Statement of Operations and Fund Balance by Fund
For the Year Ended April 30, 2000
Unaudited

Appendix 1(d)

	Unrestricted Funds				Restricted Funds			Endow - ment	Grand Total All Funds
	Operating	Clinical Services	Clinical Practice Plan	Other Specific Purpose	Total Specific Purpose	Trust	Research		
Revenues	16,698,919								16,698,919
University operating budget									
Government grants and contracts									
Government of Canada				1,309,531	1,309,531		2,500,034		3,809,565
Province of Saskatchewan		22,951,421		4,997,378	27,948,799		2,985,730		30,934,529
Other				127,562	127,562		111,338		238,900
Student Fees									
Gifts, grants and bequests				2,393,075	2,393,075	286,604	5,141,271	116,838	7,937,788
Sales of services and products			14,377,366	1,068,217	15,445,583		2,534		15,448,117
Income from investments				8,345	8,345	635,561			643,906
Miscellaneous Income				125	125	70,569	46,292		116,986
	16,698,919	22,951,421	14,377,366	9,904,233	47,233,020	992,734	10,787,199	116,838	75,828,710
Expenses									
Salaries									
Academic	11,487,001	7,363,178	10,456,159	1,231,615	19,050,952		261,890		30,799,843
Other	2,501,872	10,460,468	2,713,719	6,167,288	19,341,475	450	6,094,650		27,938,447
Employee Benefits	1,887,312	1,050,412	1,051,199	572,029	2,673,640		490,324		5,051,276
Salaries and benefits	15,876,185	18,874,058	14,221,077	7,970,932	41,066,067	450	6,846,864	0	63,789,566
Non - salary expenses	822,734	1,008,781	2,955,360	2,049,894	6,014,035	653,311	3,804,252	0	11,294,332
	16,698,919	19,882,839	17,176,437	10,020,826	47,080,102	653,761	10,651,116	0	75,083,898
Net revenues (expenses)	0	3,068,582	(2,799,071)	(116,503)	152,918	338,973	136,083	116,838	744,812
Interfund transfers		(3,068,582)	2,951,989	116,593	0				0
Contingency account adjustments									0
Net increase (decrease) in fund balances	0	0	152,918	0	152,918	338,973	136,083	116,838	744,812
Fund balances, beginning of year	1,376,854	(910,225)	127,192	8,824,463	8,041,430	4,712,998	6,818,953	7,158,020	28,108,255
Fund balances, end of year	1,376,854	(910,225)	280,110	8,824,463	8,194,348	5,051,971	6,955,036	7,274,858	28,853,067

THE UNIVERSITY OF SASKATCHEWAN

College of Medicine
Academic and Clinical Services Expenditures by Department and Fund
For the Year Ended April 30, 1997
Unaudited

Appendix 2 (a)

Department	Operating Fund		Clinical Services Fund		Clinical Practice Plan		Other Specific Purpose		Research		Total	
	Academic	Service	Academic	Service	Academic	Service	Academic	Service	Academic	Service	Academic	Service
Anesthesia	205,762	205,762	-	-	70,425	466,449	536,874	127,823	-	-	276,187	594,272
Anatomy	625,709	625,709	-	-	-	-	-	30,919	-	-	662,628	662,628
Biochemistry	878,045	878,045	-	-	-	-	-	-	-	-	878,045	878,045
Com Health & Epidemiology	349,043	349,043	-	-	-	-	-	12,500	-	-	961,543	114,660
Dean's Office	364,080	116,992	-	-	-	-	-	(2,479)	-	-	379,062	114,513
Family NARS	-	-	-	-	-	-	-	96,468	-	-	96,468	102,529
Family - Regina	184,787	184,787	-	-	-	-	-	-	-	-	233,634	199,224
Family - Saskatoon	373,908	373,908	-	-	-	-	-	-	-	-	373,908	279,737
Medical Imaging	176,330	176,330	-	-	-	-	-	25,147	-	-	412,935	1,190,574
Medicine	1,891,709	1,891,709	-	-	272,345	1,585,029	1,857,374	376,844	-	-	2,215,653	2,133,666
Microbiology	577,205	577,205	-	-	-	-	-	51,599	-	-	247,111	161,850
Nuclear Medicine	-	-	-	-	-	-	-	60,000	-	-	201,429	305,522
Obs & Gyn	263,164	263,164	-	-	-	-	-	-	-	-	314,055	295,199
Ophthalmology	119,282	119,282	-	-	-	-	-	-	-	-	119,282	161,164
Pathology	499,356	499,356	-	-	-	-	-	37,331	-	-	772,205	849,480
Pharmacy	480,723	480,723	-	-	-	-	-	107,640	-	-	1,002,557	1,267,474
Pharmacology	598,832	598,832	-	-	-	-	-	1,415	-	-	598,832	1,415
Phys Therapy	223,925	223,925	-	-	-	-	-	53,967	-	-	277,892	61,792
Physiology	803,522	803,522	-	-	-	-	-	-	-	-	803,522	803,522
Psychiatry	307,608	307,608	-	-	-	-	-	2,530	-	-	610,636	716,302
Rehabilitation	171,149	171,149	-	-	-	-	-	7,178	-	-	271,616	249,623
Surgery	689,907	689,907	-	-	307,997	1,913,323	2,301,320	248,285	-	-	1,263,261	2,161,648
Total Line Teaching	-	-	-	-	-	-	-	60,075	-	-	586,475	586,475
Rounding	(5)	(5)	-	-	-	-	-	-	-	-	(5)	(5)
	9,874,921	116,992	9,991,913	1,002,092	2,666,114	4,468,286	8,061,640	321,228	1,302,370	194,271	13,459,083	10,960,625

THE UNIVERSITY OF SASKATCHEWAN

School of Medicine

Clinical and Clinical Service Expenditures by Department and Fund

for the Year Ended April 30, 1998

Insulated

Appendix 2 (b)

Department	Operating Fund			Clinical Services Fund			Clinical Practice Plan			Other Specific Purpose			Research			Total		
	Academic	Service	Subtotal	Academic	Service	Subtotal	Academic	Service	Subtotal	Academic	Service	Subtotal	Academic	Service	Subtotal	Academic	Service	Total
anaesthesia	229,432		229,432				45,517	544,916	590,433		47,016	47,016				274,949	591,932	866,881
radiology	716,947		716,947							41,928	(33,355)	8,574				758,876	(33,355)	725,521
radiochemistry	875,275		875,275							5,900	106,411	112,311	3,049		3,049	875,275	3,049	878,324
com Health & Epidemiology	355,666		355,666								4,376	4,376	(29,487)		(29,487)	405,726	76,914	482,640
Dean's Office	469,821	119,828	589,647							121,470	123,094	244,564	48,649		48,649	469,821	170,851	640,672
Faculty - MMS																121,470	123,094	244,564
Faculty - Regina	198,307		198,307	79,801	28,170	107,971			216,466							278,108	242,636	520,744
Faculty - Saskatoon	309,562		309,562						218,768							309,562	237,806	547,368
Medical Imaging	211,186		211,186	165,853	1,232,900	1,398,753				19,038		19,038				377,039	1,247,033	1,624,072
Medicine	1,901,852		1,901,852	14,223	145,600	159,823							2,468		2,468	2,301,583	1,944,465	4,246,048
Microbiology	625,343		625,343	100,045	103,557	203,602			1,872,077	81,515	227,813	309,328	500		500	861,067	106,822	967,889
Nuclear Medicine							138,554	157,639	296,193							138,554	157,639	296,193
Obst & Gyn	311,945		311,945	43,608	10,333	54,141			350,033							355,753	360,366	716,119
Ophthalmology	127,950		127,950		100,000	100,000			160,904							127,950	260,904	388,854
Otolaryngology	488,744		488,744	327,032	858,784	1,185,816										815,776	910,125	1,725,901
Pathology	502,982		502,982	133,952	137,386	271,338	427,295	1,120,097	1,547,392				46,271		46,271	1,079,203	1,419,394	2,498,597
Pharmacology	614,366		614,366							34,061	1,138	35,199				648,427	1,138	649,565
Phys Therapy	258,140		258,140													331,285	58,396	389,681
Physiology	766,025		766,025													780,056	19,580	799,636
Psychiatry	430,455		430,455	276,970	22,920	299,890			813,014				19,580		19,580	707,375	697,754	1,405,129
Psychology	186,159		186,159	28,694	307,606	336,300				4,218	37,177	41,395				306,257	400,408	706,665
Rehabilitation	771,746		771,746		812,400	812,400	499,948	2,365,186	2,865,134	6,189	299,379	305,568				1,277,883	3,476,965	4,754,848
Registry				548,063		548,063										548,063		548,063
Art line teaching					(155)	(155)			15							50	(140)	(90)
Nursing	50		50															
Unallocated Retro					2,834	2,834												
	10,351,953	119,828	10,471,779	1,817,281	3,760,351	5,577,642	1,414,807	7,315,622	8,730,429	368,427	1,133,401	1,501,828	218,530	147,410	365,940	14,171,008	12,476,610	26,647,618

UNIVERSITY OF SASKATCHEWAN
College of Medicine
Academic and Clinical Service Expenditures by Department and Fund
for the Year Ended April 30, 1999
Audited

Appendix 2 (c)

[illegible]

For the 1988
Uninsured

Appendix 2 (d)

Department	Operating Fund		Clinical Services Fund		Clinical Practice Plan		Other Specific Purpose		Research		Academic		Total
	Academic	Service	Academic	Service	Academic	Service	Academic	Service	Academic	Service	Academic	Service	
Anesthesiology	264,737				78,389	395,439	473,828	47,016			343,146	442,455	785,601
Anatomy	803,915							41,929			845,844		845,844
Biochemistry	1,057,738										1,057,739		1,057,739
Com Health & Epid	292,219		20,000	20,000				65,580		44,160	342,279	85,580	427,859
Dean's Office	409,572	108,417									409,572	108,417	517,989
Family - H&S													
Family - Regene	205,899		107,132	50,000		242,130	242,130				121,470	123,094	244,564
Family - Sastaboon	320,082			50,000		235,750	235,750				313,031	292,130	605,161
Medical Imaging	163,983		281,578	1,431,434				2,083			320,062	287,833	607,895
Medicine	2,163,200		46,000	192,813	457,718	2,267,290	2,725,008				425,542	1,432,567	1,858,109
Microbiology	729,482		174,472	113,529				1,133			961,833	115,729	1,077,562
Nuclear Medicine										500	2,748,933	2,624,453	5,373,386
Obst & Gyn.	394,870		37,478	110,559		344,398	344,398				432,148	454,957	887,105
Ophthalmology	137,588			150,000	48,000	232,569	280,569				185,586	382,569	568,155
Otolaryngology	537,508		394,281	978,350		1,372,631					931,787	1,001,683	1,933,470
Pediatrics	677,363		217,172	530,216	467,984	1,080,385	1,548,369	115,640		56,134	1,377,493	1,767,401	3,144,894
Pharmacology	630,653							17,432		14,974	648,085		648,085
Phys Therapy	271,522							73,145			271,522	73,145	344,667
Physiology	882,724										896,755		896,755
Psychiatry	496,603		283,730	433,450		737,330	737,330	56,436		14,031	780,333	1,227,216	2,007,549
Rehabilitation	152,055		60,933	250,050				13,210		87,186	300,174	263,260	563,434
Surgery	699,905			845,000	636,284	2,139,760	2,776,044	272,160			1,342,378	3,256,920	4,599,298
Part time teaching			625,000								625,000		625,000
Vacant Positions	87,189					1,092,733	1,092,733				87,189	1,092,733	1,179,922
	11,378,584	108,417	2,207,777	5,155,401	1,688,375	8,767,784	10,456,159	957,180		218,530	15,767,701	15,032,142	30,799,843

Private Practice Pre-Tax Income to Full Time Faculty Average Gross Salary

A Private Practice (1)

	Anaesthesia	Family Med	Obstetrics & Gynaecology	Ophthalmology	Pediatrics	Infectious Diseases	Psychiatry	Neurology	Orthopedic	General Surgery	Cardio-Thoracic	Agriculture	Cardiology
Number in Group	41	257	21	17	14		20		18	43		19	13
Minimum billing	127,221	48,393	109,307	86,692	58,819		47,304		187,819	66,522		55,969	283,263
Maximum billing	426,713	344,068	638,716	1,278,143	342,910		555,780		660,598	463,178		718,096	1,228,204
Average billing	209,095	159,369	324,478	511,813	199,992		230,724		334,681	249,878		262,458	520,474
Estimated overhead rate (2)	20.0%	40.0%	40.0%	40.0%	37.5%		30.0%		35.0%	37.5%		37.5%	37.5%
Net billing before income tax	167,756	95,821	194,687	307,068	124,995		161,507		217,543	156,174		164,036	325,296
"Employer expenses" (3)	10,500	10,500	10,500	10,500	10,500		10,500		10,500	10,500		10,500	10,500
Estimated net pre-tax income	157,256	85,121	184,187	296,568	114,495		151,007		207,043	145,674		153,536	314,796

B Full Time Faculty

Number in Group	46	60	40	20	100	40	70	10	40	70	30	10	40
Actual Average Salary (4)	60,040	63,125	53,670	59,175	64,151	77,277	65,823	46,409	63,652	65,339	58,724	90,852	65,865
Service supplement (6)													
Service billings (7)	129,190	45,870	71,300	80,582	63,185	126,955	75,791	140,280	96,018	62,818	332,310	47,000	81,691
Total	189,230	108,995	124,970	139,757	127,336	204,232	141,614	186,779	159,670	128,157	391,034	137,852	147,556
Private Practice higher (lower) than faculty	(31,974)	(23,874)	59,217	156,831	(12,841)	N/A	9,393	N/A	47,373	17,517	N/A	15,684	167,240
Index (11)	0.83	0.78	1.47	2.12	0.90	N/A	1.07	N/A	1.30	1.14	N/A	1.11	2.13

Footnotes:

- 1) Data on number in group, minimum billing, maximum billing, and average billing obtained from Saskatchewan Health. This data excludes College of Medicine, Community Clinics, and Alternate Payment Projects.
- 2) Overhead rates are based on a 1992 Saskatchewan Medical Association survey.
- 3) "Employer expenses" are an estimate of the value of the employer's share of employee benefits which are assumed not to be included within the overhead rate percentages of private practices. The allowance of \$10,500 is the approximate average cost of the College's share for employee benefits.
- 4) Average actual salaries paid in fiscal year ending April, 1997 - excludes faculty members with partial first year or partial fiscal year. Includes retroactive pay on academic component.
- 5) Academic Salaries - reflects all academic salaries regardless of source of funding. Sources of funding for academic services include the Operating Fund, Clinical Services Fund, Other Special Purpose Fund and Research Fund.
- 6) Service Supplement - only implemented for certain services in 1997/98, therefore no figures are reported in this category for 1996/97.
- 7) Service salary is derived from Clinical Practice Plan revenues.
- 8) There are no private practice comparisons for Agriculture, Endocrinology, Haematology, Infectious Diseases, and Pharmacology, and therefore General Internal Medicine is used as the private practice benchmark.
- 9) The index is calculated as private practice estimated net average pre-tax income divided by faculty actual average salary.

Clinical Practice Plan Departments
Comparison of Estimated Average
1996/97

Private Practice Pre-Tax Income to Full Time Faculty Average Gross Salary

Appendix 3(a) - p. 2 of 2

A. Private Practice (1)

	(8) Dermatology	(8) Endo- crinology	(8) Gastro- enterology	(8) Internal Medicine General	(8) Haemat- ology	(8) Infectious Diseases	(8) Nephrology	(8) Neurology	(8) Pharma- cology	(8) Respir- atory	(8) Rheumat- ology
Number in Group	5	19	4	19	19	19	5	4	19	3	3
Minimum billing	137,211	55,969	328,067	55,969	55,969	55,969	165,799	145,113	55,969	274,748	201,238
Maximum billing	283,876	718,096	504,506	718,096	718,096	718,096	500,049	461,027	718,096	311,607	476,369
Average billing	212,023	262,458	386,287	262,458	262,458	262,458	353,955	288,711	262,458	288,179	302,134
Estimated overhead rate (2)	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%
Net billing before income tax	132,514	164,036	241,429	164,036	164,036	164,036	221,222	180,444	164,036	180,112	168,834
"Employer expenses" (3)	10,500	10,500	10,500	10,500	10,500	10,500	10,500	10,500	10,500	10,500	10,500
Estimated net pre-tax income	122,014	153,536	230,929	153,536	153,536	153,536	210,722	169,944	153,536	169,612	178,334

B. Full Time Faculty

Number in Group	10	20	20	10	20	10	20	30	10	50	30
Actual Average Salary (4)	59,939	85,253	73,330	48,257	78,807	69,808	70,109	78,153	70,396	68,130	65,211
Service supplement (6)	73,497	48,500	46,834	47,000	67,559	58,667	45,500	58,457	47,000	62,465	46,000
Service binnings (7)	133,436	133,753	120,164	95,257	146,366	128,475	115,609	136,610	117,396	130,595	111,211
Private Practice higher (lower) than Faculty	(11,422)	19,783	110,765	58,279	7,170	25,061	95,113	33,334	36,140	39,017	67,123
Index (9)	0.91	1.15	1.92	1.61	1.05	1.20	1.82	1.24	1.31	1.30	1.60

Footnotes:

- 1) Data on number in group, minimum billing, maximum billing, and average billing obtained from Saskatchewan Health. This data excludes College of Medicine, Community Clinics, and Alternative Payment Projects.
- 2) Overhead rates are based on a 1992 Saskatchewan Medical Association survey.
- 3) "Employer expenses" are an estimate of the value of the employer's share of employee benefits who are assumed not to be included within the overhead rate percentages of private practices. The allowance of \$10,500 is the approximate average cost of the College's share for employee benefits.
- 4) Average actual salaries paid in fiscal year ending April, 1997 - excludes faculty members with partial first year or partial final year. Includes retroactive pay on academic component.
- 5) Academic Salaries - reflects all academic salaries regardless of source of funding. Sources of funding for academic services include the Operating Fund, Clinical Services Fund, Other Special Purpose Fund and Research Fund.
- 6) Service Supplement - only implemented for certain services in 1997/98, therefore no figures are reported in this category for 1996/97.
- 7) Service salary is derived from Clinical Practice Plan revenues.
- 8) There are no private practice comparisons for Agriculture, Endocrinology, Haematology, Infectious Diseases, and Pharmacology, and therefore General Internal Medicine is used as the private practice benchmark.
- 9) The index is calculated as private practice estimated net average pre-tax income divided by faculty actual average salary.

Clinical Practice Plan Departments
Comparison of Estimated Average Private Practice Pre-Tax Income to Full Time Faculty Average Gross Salary
1997/98

Appendix 1(b) - p. 2 of 2

A. Private Practice (1)

	(8) Endo - crinology	(8) Gastro - enterology	(8) Internal Medicine General	(8) Haemat - ology	(8) Intensive Care Unit	(8) Infectious Diseases	(8) Nephrology	(8) Neurology	(8) Pharma - cology	(8) Respi - ratory	(8) Rheumat - ology
Number in Group	4	19	19	19	19	19	5	6	19	4	4
Minimum billing	141,837	331,765	56,577	56,577	56,577	56,577	196,980	141,551	56,577	158,158	241,810
Maximum billing	289,177	505,422	704,229	704,229	704,229	704,229	474,071	444,322	704,229	323,575	469,601
Average billing	237,987	391,066	269,163	269,163	269,163	269,163	353,961	283,704	269,163	253,253	311,554
Estimated overhead rate (2)	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%	37.5%
Net billing before income tax	148,742	246,129	168,227	168,227	168,227	168,227	221,226	177,315	168,227	158,283	194,721
"Employer expenses" (3)	10,500	10,500	10,500	10,500	10,500	10,500	10,500	10,500	10,500	10,500	10,500
Estimated net pre-tax income	138,242	235,629	157,727	157,727	157,727	157,727	210,726	166,815	157,727	147,783	184,221

B. Full Time Faculty

Number in Group	1.0	2.0	2.0	2.0	2.0	1.0	2.0	3.0	2.0	5.0	3.0
Actual Average Salary (4)	86,619	80,090	49,666	85,619	66,541	66,541	76,503	79,003	88,038	78,169	70,506
Academic (5)											
Service supplement (6)											
Service billings (7)	53,233	48,367	50,463	72,592	51,333	51,333	53,833	51,455	44,117	61,131	45,278
Total	N/A	139,852	128,457	158,211	N/A	117,874	130,336	130,458	132,155	139,300	115,784
Private Practice higher (lower) than Faculty	N/A	17,875	107,172	57,598	(484)	39,853	80,390	36,357	25,572	8,483	68,437
Index (9)	N/A	1.13	1.63	1.58	1.00	1.34	1.62	1.28	1.19	1.06	1.59

Footnotes:

- 1) Data on number in group, minimum billing, maximum billing, and average billing obtained from Saskatchewan Health. This data excludes College of Medicine, Community Clinics, and Alternate Payment Projects.
- 2) Overhead rates are based on a 1992 Saskatchewan Medical Association survey.
- 3) "Employer expenses" are an estimate of the value of the employer's share of employee benefits which are assumed not to be included within the overhead rate percentages of private practices. The allowance of \$10,500 is the approximate average cost of the College's share for employee benefits.
- 4) Average actual salaries paid in fiscal year ending April, 1998 - excludes faculty members with partial first year or partial final year. Includes retroactive pay on academic component.
- 5) Academic Salaries - reflects all academic salaries regardless of source of funding. Sources of funding for academic services include the Operating Fund, Clinical Services Fund, Other Special Purpose Fund and Research Fund.
- 6) Service Supplement - reflects the average supplement paid from the Clinical Services Fund. For Neurosurgery, Saskatchewan Health flows the supplement into the Neurosurgery Practice Plan.
- 7) Service salary is derived from Clinical Practice Plan revenues.
- 8) There are no private practice comparisons for Agriculture, Endocrinology, Haematology, Infectious Diseases, and Pharmacology, and therefore General Internal Medicine is used as the private practice benchmark.
- 9) The index is calculated as private practice estimated net average pre-tax income divided by faculty actual average salary.

Appendix 4: Interviewees and Correspondents

Name	Title	Department	Organization
Borden, Lois	Executive Director	District Support Branch	Sask Health
Donnelly, Lauren	Executive Director	Acute and Emergency Services	Sask Health
Fimesz, Bob	Acting Executive Director Director Alternate Payments	Medical Services Branch	Sask Health
Hendricks, Max	Senior Program Consultant	Medical Services Branch	Sask Health
Klassen, Carol	Executive Director	Acute and ER Services	Sask Health
Krahn, Lawrence	Executive Director (Formerly Assistant Deputy Minister)	Medical Services Branch	Sask Health
Layng, Karen	Executive Director	Primary Health Services	Sask Health
Linklater, Bert		District Support Branch	Sask Health
Magnusson, Donna		Medical Services Branch	Sask Health
McMillan, Stewart	Family Physician, Regina	Medical Consultant	Sask Health
Richter, Kelly		District Support Branch	Sask Health
Yeske, Maureen	Executive Director	Policy and Planning Branch	Sask Health
Bergen, Jeff	Administrative Assistant	Administration and Finance	COM
Bowen, Rudy	Academic Head	Psychiatry	COM
Campbell, David	Director, Research	Anesthesia	COM
Card, Bob	Associate Dean	Undergraduate Medical Education	COM
Cotton, David	Academic Head	Medicine	COM

Donat, JR	Neurologist	Medicine	COM
Goplen, Gary	Associate Professor	Neurosurgery	COM
Hader, Walter	Academic Head	Physical Medicine and Rehabilitation	COM
Harrison, Elizabeth	Assistant Dean and Director Chair, HSURC	Physical Medicine and Rehabilitation	COM
Kalra, Jawahar	Academic and Clinical Head	Laboratory	COM
Keegan, David	Clinical Head	Psychiatry	COM
Keith, Roger	Academic Head	Surgery	COM
Korchinsky, Larry	Sr Full-Time Faculty	Family Medicine	COM
Melvin, Greg	Associate Director	Administration and Finance	COM
Mohamed, M Faizel	Academic Head Acting Executive Director Director	Oncology Saskatoon Cancer Centre Radiology/Oncology Dept (SHD)	COM
MacDonald, Ian	Former Dean		COM
McLennan, Barry	Assistant Dean	Research	COM
McKinstry, Lynn	Acting Associate Dean	Postgraduate Medicine Education	COM
Popkin, David	Dean		COM
Qualtiere, Lou	Academic Head	Microbiology	COM
Reynolds, Barry	Program Director	Anesthesia	COM
Romanchuk, Ken	Academic Head	Ophthalmology	COM
Rosenburg	Academic and Clinical Head	Pediatrics	COM
Spooner, Jim	Head	Continuing Medical Education	COM
White, Gil	Academic Chair	Family Medicine	COM
White, Syl	Director	Administration and Finance	COM

Yip, Raymond	Academic Head	Anesthesia	COM
Bartlett, Glenn	President and CEO		Regina Health District
Begg, Bob	Chief of Staff		Saskatoon Health District
Bercheid, Bruce	Clinical Head	Medical Imaging	Saskatoon Health District
Cameron, Bob	Former Academic Head (Regina)	Surgery	Plains Surgical Assoc., Regina
Ferguson, Jim	President and CEO		Saskatoon Health District
Hardcastle, Steve	Vice-President	Finance	Saskatoon Health District
Heidt, Brian	CEO		Lloydminster Health District
Hadubiak, Greg	CEO	Kindersley	Prairie West Health District
Lockhart, Drew	CEO		Swift Current Health District
Maber, Barry	Physician Vice-President	Medical Services	Saskatoon Health District
Millar, James	CEO		West Health District
Pylypchuk, George	Clinical Head	Medicine	Saskatoon Health District
Rivers, Len	Clinical Head	Surgery	Saskatoon Health District
Rice, Stan	CEO		Prince Albert Health District
Rourke, Brian	Board Member		Saskatoon Health District
Ulvick, Rayann	CEO		Northeast Health District
Yarske, John	CEO		Battlefords Health District
Young, Linda	V-P	Medical Services	Regina Health District

Atkinson, Michael	V-P, Academic	Executive	U of S
Dubray, Barrie	Director	Institutional Research	U of S
Ivany, George	President	Executive	U of S
Jamison, Rick	Director, Budget Management	Finance	U of S
Kennedy, Laura	Associate Vice-President	Finance	U of S
Llewellyn, Joan	Director	Academic Administration	U of S
Summers, Terry	Manager, Financial Reporting	Finance	U of S
Webster, Matt	Director, Accounting Services	Finance	U of S
Whitworth, Tony	V-P, Finance	Executive	U of S
Bocor, Marc	President	(Endocrinology) Medicine	Saskatoon District Medical Society
Bohm, Eric	President		Professional Association of Interns and Residents
Brooks, Peter	Executive Dean	Health Sciences	University of Queensland
Ferguson, Judy	Executive Director	Audit	Provincial Auditor, Saskatchewan
Hawkins, David	Executive Director		Assoc. of Canadian Med Colleges, Ottawa
Hobday, Ed	- Administrative Director		SMA
Jersak, Rodd	Manager	Audit	Provincial Auditor, Saskatchewan
Kendel, Dennis	Registrar		CPSS

Kirchgesner, Daniel	Board Member, President		SMA
Saxinger, Lynora	President		Professional Association of Interns and Residents
Scharfstein, Briane	Executive Director		SMA
Shaw, Susan	Executive Director		Professional Association of Interns and Residents
Wahba, Mark	President	Student Medical Society	Student Medical Society
Weiler, Rob	Board Member		SMA
Biss, John			Postsecondary Education
Coleman, Glenys	Recruitment Coordinator		Consultant to Sask Health
Henning, Terry	Family Physician, Humboldt	President and CEO Taipan Consulting	Humboldt, Sk
Perrins, Dan	Deputy Minister		Postsecondary Education

Appendix 5: Terms of Reference

ACCOUNTABILITY

1. Review and document the College's governance structure and assess its adequacy to the University, government and the health system. Explore alternative governance structures for the College, identify the advantages and disadvantages of each and recommend the preferred structure to achieve optimal accountability and sustainability.
2. Assess the College's reporting requirements both to the University and to government, its compliance, its decision making forums and management structures and recommend any necessary changes.
3. Assess the College of Medicine's success in meeting the province's physician resource needs historically and how well positioned it is to meet current and future resource needs? Recommend any changes which in your view would better address this issue.
4. Assess the College's recruitment process for academic positions and the allocation of teaching and residency positions by specialty and training location, including the roles played by the health districts, and particularly the Saskatoon Health District, in the recruitment and allocation process. Recommend changes which would improve this process, lead to greater stability and better meet the province's current and future resource requirements.

FUNDING

1. Review the base funding for the College of Medicine, including all sources of funding, to determine how academic positions are being funded both in terms of the academic, research and service portions of their incomes. Recommend any changes deemed necessary in the current funding arrangements.
2. Assess the compensation levels of the residents and faculty, how these compare across faculties, with other Colleges of Medicine and with their fee-for-service colleagues. Recommend adjustments which are necessary to address issues of fairness and adequacy and provide the basis for your recommendations.
3. Assess the adequacy of the current financial and resource allocation reporting requirements to government and the University and recommend any necessary modifications deemed necessary to ensure that financial accountability is sufficient.
4. Given that there are currently several funding sources for the College of Medicine, assess alternative funding arrangements, provide the advantages and disadvantages of each and recommend the preferred arrangements to address future sustainability and accountability.

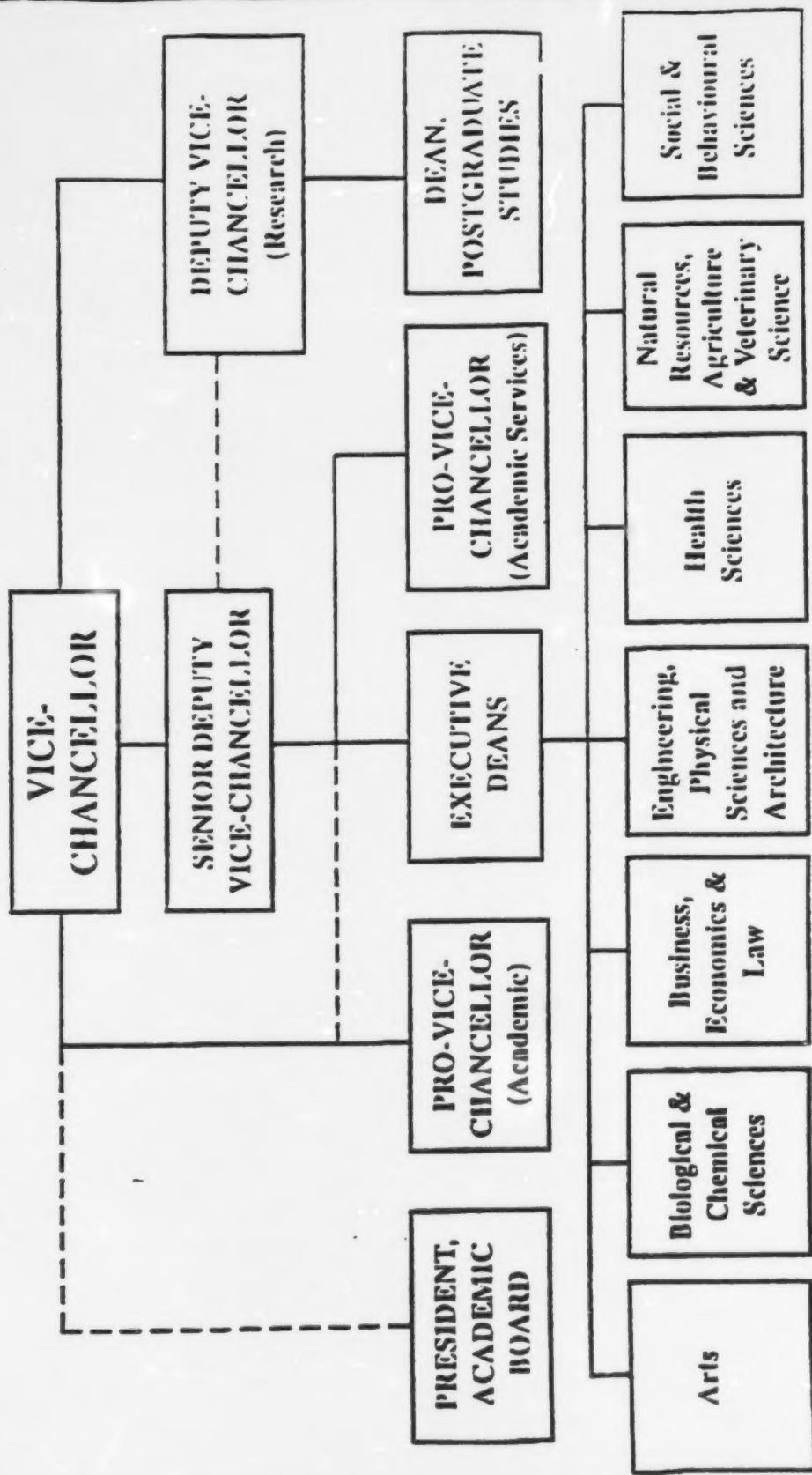
Appendix 6: Documents Reviewed

1. Sept. 1977. Report of the Committee on Service Funding of the College of Medicine University of Saskatchewan. Department of Health, Department of Continuing Education.
2. March 1989. Towards a New Beginning: Review of the College of Medicine University of Saskatchewan. Kerr White.
3. November 1997. Final Report to the Medical Council from the Working Group on Physician Need on Establishing and Maintaining Specialty Physician Services in Rural and Urban Saskatchewan.
4. DJ Buchan. Greenhouse to Medical Centre, Saskatchewan's Medical School 1926-78.
5. Saskatchewan Liaison Committee of Medical Education Terms of Reference-Last Revised October 1996.
6. Review of Kerr White Report by the Working Group on PG Clinical Education.
7. University of Saskatchewan Institutional Self-Study Report, January 1995.
8. Agreement between Saskatoon District Health Board Corp. and U of S with respect to University Academic Purpose and Research Operative in the Saskatoon District Health Board Corporation Facilities.
9. Agreement between U of S and Regina Hospitals.
10. Minutes of committee of department heads, minutes of resource allocation committee of the college of medicine, minutes of the faculty council and minutes of the executive committee of the faculty council.
11. Organizational chart of the College of Medicine, organizational chart Dean of Medicine's office, faculty council rules and regulations-existing and proposed.
12. May 1991. The College of Family Physicians of Canada Onsite Survey Report: Residency Training Program in Family Medicine University of Saskatchewan.
13. May 1991. Royal College of Physicians and Surgeons of Canada On-Site Survey of Specialty Residency Training Programs, University of Saskatchewan Chairman's Report.
14. October 1997. University of Saskatchewan Report of the Accreditation Team: Residency Training Program in Family/Emergency Medicine.
15. May 1997. Report of the visit of the LCME/CACMS Secretariat to the University of Saskatchewan College of Medicine.
16. October 1997. University of Saskatchewan Report of the Accreditation Team Residency Training Program in Family Medicine.
17. November 1997, January and April 1998. Saskatchewan Medical Council Minutes.
18. Department of Medicine, College of Medicine, University of Saskatchewan Annual Report 1996-97.

19. April 1998. University of Saskatchewan Dean of Medicine's Committee of Department Heads Review of College Financing.
20. Department of Medicine's Five Year Plan 1995-2000: Planning the Future of the Academic Department of Medicine.
21. 1997. List of Major Tertiary Care Programs, Department of Internal Medicine, Royal University Hospital, Saskatoon Saskatchewan.
22. June 1998. College of Medicine Review Panel Orientation-Medical Services Plan.
23. Saskatoon College of Medicine Terms of Reference, Review Questions and Answers
24. 1997-98 Clinical Services Fund of the College of Medicine Service Agreement Between the Board of Governors of the U of S and the Government of Saskatchewan.
25. College of Medicine, University of Saskatchewan, Dean of Medicine's Office Statement of Objectives, Authority and Responsibility.
26. Collective Agreement between the U of S and PAIRS for the Period January 1, 1995-December 31, 1998.
27. 1995-1998 Collective Agreement between the U of S and the U of S Faculty Association.
28. Final Report to the COM Faculty Council from the Committee to Review the Rules and Regulations of the Faculty Council and Administrative Procedures, April 17, 1998.
29. Rules, Regulation and Administrative Procedures, COM, U of S, Revised October 1994.
30. COM Part-Time Teaching Agreement.
31. Agreement Between Individual Faculty Members of the COM and the University Related to Professional Fees.
32. Clinical Practice Plan, COM, U of S Annual Report, for the Period Ended April 30, 1997 and for the Period Ended April 30, 1996.
33. Revised Budget for the Clinical Services Fund 1998-99, the First Financial Forecast for 1998-99 and the Clinical Services Fund Management Plan for 1998-99.
34. Demographic and Earnings Survey of Full-Time Faculty, Canadian Faculties of Medicine, 1992/93.
35. Report on Earning for the Demographic and Earnings Survey of Full-Time Faculty, Canadian Faculties of Medicine, 1992/93.
36. August 1997, Recommendations of the Working Group on Physician Need for the Provision of Specialist Services in Rural and Urban Saskatchewan.
37. November 18, 1997, Final Report to the Medical Council from the Working Group on Physician Need for Establishing and Maintaining Specialty Physician Services in Rural and Urban Saskatchewan.

38. June, 1998. College of Medicine Review Panel Orientation: Medical Services and Health Registration Branch with
- Budget and First Financial Forecast (1996/97)
 - Annual Report of the Clinical Services (Year Ended March 31, 1997)
 - Report of the Accreditation Team (Residency Training Program in Family Medicine, Oct. 1997)
 - Health Services Survey Commission
 - Clinical Services Fund Agreement (COM)
39. June 1998. Review Panel Orientation-Medical Services Plan with
- Funding Overview
 - Medical Education
 - Reporting Structures
 - Background on Recent Developments
40. Minutes of committee of department heads, minutes of resource allocation committee of the college of medicine, minutes of the faculty council and minutes of the executive committee of the faculty council.
41. The Department of Medical Imaging Package with
- Background of the Department
 - 1996-97 Clinical Services Fund Agreement (COM)
 - Subsidiary Agreement
 - Plan for Department Revitalization
42. May 1998. Position Paper for the College of Medicine Review Committee by the Department of Family Medicine including
- Background on the Rural Family Medicine Program
 - Background on the Health Transition Pilot Project
 - Background on the Rural Medical Service
 - Department of Family Medicine Financial Statements
 - Faculty Renumeration
43. September 1997. Saskatchewan University Funding Review, Interim Report. The Discovery Phase. Edward Desrosiers and Associates.
44. Paul Cappon and Diane Watson. Improving the Social Responsiveness of Medical Schools: Lessons from the Canadian Experience.

OUTLINE ACADEMIC ORGANISATION FROM 1997



Appendix 8: Summary of Recommendations:

Governance

Recommendation:

We recommend that the University of Saskatchewan close the gap between the Board and the College of Medicine by establishing a sub-Board for Health Sciences.

Recommendation:

The College of Medicine should take stock of its past and present, and chart a course towards the future, with a widespread iterative and transparent process to establish Vision and Mission, based on enunciated values. This exercise should be commenced as soon as is reasonably possible. It must be completed prior to the commencement of the next academic year (September 1999).

Recommendation:

We recommend the establishment of the position of Vice-President Health Sciences as the overall management executive responsible for Health Sciences. We recommend that once the Vice-President of Health Sciences position has been established and is operational and the sub-Board for Health Sciences has been established and operational, meaningful work should commence to examine the implications, costs and benefits of merging all Health Sciences, with the endpoint of consideration being the establishment of a position of Vice-President and Executive Dean for Health Sciences.

Recommendation:

A clear understanding must be developed with respect to fulfilling the social contract and responsibilities of the College of Medicine to the Province of Saskatchewan. This should include, but not be limited to, meaningful involvement in the continuing and dynamic development of physician manpower plans for the Province, as well as commitments and approaches to physician recruitment and retention. Such understanding in regards to the social contract should include explicit performance indicators, and targets for recruitment of undergraduate- and post-graduate trainees upon completion of their programs.

Recommendation:

We recommend that there be thorough review of the Clinical Services Fund, including all aspects of expenditures and uses of the Fund, with ultimately a clearly documented and renewed understanding in the form of a Clinical Services Fund Agreement between the University of Saskatchewan and Saskatchewan Health.

Management

Recommendation:

We recommend that the Dean's office management be restructured, establishing three full-time positions:

- Associate Dean - Clinical Services
- Associate Dean - Research
- Associate Dean - Education

For clinical services the Associate Dean would be second-in-charge to the Dean. Academic Heads would report to the Associate Dean Clinical Services for all aspects of clinical services delivery. It is understood that reporting relationships between the Academic Heads to the Dean's office should be, where possible, through the Associate Deans.

Recommendation:

We recommend that the Dean revitalize his Executive Committee to include the new management positions, meeting on a weekly basis, with an aggressive and proactive agenda to reshape the College of Medicine, congruent with this Review.

Recommendation:

We recommend that the Dean establish a Planning and Priorities Committee to provide senior-level advice of a strategic nature to the Dean and Executive. The positions for the Planning and Priorities Committee should be subjects of election from the faculty, with two positions from Basic Sciences, two from Clinical Sciences, one from Community Health Sciences and one being the Associate Dean Clinical Services.

Recommendation:

We recommend that fastidious attention be paid to attendance at senior management meetings of the Dean and the Saskatoon Health District, with the Physician Vice-President Medical Services, Saskatoon Health District, attending the Dean's Executive, and Chief of Staff, Saskatoon Health District, attending the Academic Head's meetings; and, the Dean or Associate Dean Clinical Sciences attending the Senior Leadership Team meetings of Saskatoon Health District.

Recommendation:

Recognizing effective communications as being a critical success factor, we recommend establishment of a position of Officer in Communications, Public Relations and Fund Raising.

Recommendation:

We recommend that the Academic and Service Heads positions for the College of Medicine and Saskatoon Health District be integrated, so as to have a single incumbent chosen for both academic achievement and respect amongst clinicians, and ability to manage clinical services.

Recommendation:

We recommend that consideration be given to revising the Medical Advisory Committee to achieve effective input from all clinical Academic Heads, in those cases where they are not correspondingly the Service Heads for the Saskatoon Health District.

Recommendation:

We recommend that Regina be incorporated as a strong and continuing component of the College of Medicine's Mission. Regina's contribution to the College of Medicine should be included within the larger Vision and Mission that must be developed. This should include a clear, thoughtful understanding with respect to the roles and responsibilities that will be assumed in Regina and, furthermore, resources necessary to achieve these.

Funding

Recommendation:

We recommend that the projected deficit of the CSF at April 30, 1999 be eliminated on a one-time basis by Saskatchewan Health (\$533,705) & UofS (\$376,295).

Recommendation:

We recommend that Saskatchewan Health increase funding by \$2.909 million for the 1999/00 fiscal year.

Recommendation:

We recommend that the funding for academic activity be applied as follows:

To the existing shortfall in base funding	\$1,204,000
To faculty compensation	887,000
To supply cost increases	<u>75,000</u>
Total academic activity funding per above	<u>\$2,166,000</u>

Recommendation:

We recommend that an equitable solution for faculty compensation including Medical Imaging, be accomplished within an amount of \$3,167,000 (\$2,000,000 of funding provided to date plus \$280,000 previous Neurosurgery funding, and \$887,000 new funding). To achieve equity would require the establishment of a defensible compensation policy for all faculty (including Neurosurgery and Medical Imaging).

Recommendation:

We recommend that professional human resources advice be utilized to establish an appropriate compensation policy for the College of Medicine, with specified objectives to ensure that internal and external equity is achieved, and that recruitment and retention of highly qualified faculty is sustainable over the long term. No new funding for faculty compensation in 1999/00 should be advanced until a commitment is made to establish and implement a comprehensive faculty compensation policy.

Recommendation:

We recommend that in order to achieve internal and external equity, that compensation adjustments made to date be open to revision, such that the total compensation increases for all applicable College of Medicine faculty be achieved within the total funding of \$3,167,000.

Recommendation:

We recommend that the compensation policy of College of Medicine faculty be formally approved by the Finance and Audit Committee of the University of Saskatchewan, to ensure that the appropriate due diligence has been applied, and that an equitable solution has been achieved.

Recommendation:

We recommend that the Association of Canadian Medical Colleges undertake a national faculty compensation survey of Canadian medical schools on a priority basis, and that the results of this survey provide an additional basis for finalization of compensation levels for the College of Medicine.

Recommendation:

We recommend that appropriate consultation occur between the College of Medicine, Saskatchewan Health, and the Saskatoon Health District regarding future program enhancement requests as identified in Section 7.4.2.2.

Recommendation:

We recommend that certain academic services of the College of Medicine continue to be funded through the Clinical Service Fund, with the contract between Saskatchewan Health and the University of Saskatchewan to include the specified academic services to be provided, and a requirement for consultation with the Department of Post-Secondary Education in regards to actions that are under consideration.

Recommendation:

We recommend that the University of Saskatchewan annual budget be a consolidated budget, inclusive of all of the Funds of all of the Colleges, and not only the Operating Funds.

We recommend that budgets be prepared for key projects and activities that are planned by the College of Medicine in regards to Other Specific Purpose, Trust, Research and Endowment Funds. There are approximately 750 accounts within these Funds, with designated signing authorities. Presenting a plan for the top 20 accounts (or other appropriate sample), as measured by the account balance at the end of the previous year, will provide a useful indication of the types of activities that will be undertaken, and allow a year-end report to be presented on accomplishments in relation to the plan.

We recommend that the annual University of Saskatchewan audited consolidated financial statements include the approved consolidated budget as a reference column in the Statement of Operations.

We recommend that the College of Medicine prepare on an annual basis, a management discussion and analysis document of the College of Medicine's segment of the consolidated financial statements, explaining significant variances between actual results and the budget, and also from one year to the next.

We recommend that the College of Medicine implement a planning cycle that extends beyond the upcoming year to ensure that future key directions are established and to have a better opportunity to anticipate and adjust to change.

Accountability

Recommendation:

We recommend that the Medical Liaison and Planning Committee be encouraged to continue with a proactive agenda, formulated to fulfill the Affiliation Agreement between the Saskatoon Health District and the College of Medicine. We further recommend that this Committee have a fundamentally important role in reviewing and implementing the spirit and intent of this Review.

Recommendation:

In order to increase the accountability of the College of Medicine, it is recommended that the College of Medicine, after consultation with its key stakeholders, create, test and use a balanced scorecard or performance indicators. The balanced scorecard developed will include financial, customer, internal process, and employee measures of performance. It is also recommended that the College of Medicine more explicitly and formally align its diverse missions to its day-to-day management activities and processes.

Recommendation:

In order to increase the accountability of the College of Medicine with government and the public, after extensive consultation with its key stakeholders and funders, it is recommended that the College produce and promulgate an annual community report card that identifies and tracks relevant and valued performance indicators. The report card should include stable indicators that address measurable performances in education, research and service achievements.

Recommendation:

Search and Selection processes and committees designed to choose academic faculty and leadership should be reviewed. Currently, there is no direct or sufficiently meaningful participation of the Health Districts in decisions to choose academic faculty. We recommend that the Collective Agreement of the Faculty Association be reviewed in relation to requirement for and implications of Saskatoon Health District's participation in Search and Selection Processes.

Manpower/Physician Resources and Supports

Recommendation:

We recommend that the College of Medicine develop a comprehensive manpower plan, as a critical component of the provincial manpower plan. This should commence with a thorough reconsideration of the Faculty Establishment to be considered initially within divisions and departments, and subsequently across the entire College. Within the plan, there should be estimates and justification of the numbers of full-time, without-term and part-time faculty needed to fulfill the goals and objectives of the COM in teaching, research, and service delivery.

Recommendation:

We recommend that the College of Medicine, together as a key stakeholder with other respective parties, including but not limited to, the Saskatchewan Medical Association, the College of Physicians and Surgeons of Saskatchewan, and Saskatchewan Association of Health Organizations and Saskatchewan Health maintain a province-wide medical manpower planning process, using the November 1997 Report, *Establishing & Maintaining Specialty Physician Services in Rural and Urban Saskatchewan*, as a basis for further consideration. The provincial plan must incorporate the renewed Faculty Establishment.

Recommendation:

We recommend continuation of the Recruitment Coordinator's role, with expansion in the time commitment and the scope of duties to include recruitment of Postgraduate Medical Education trainees to specialty positions. In re-shaping the contract with the Recruitment Coordinator, we recommend that the position be more closely aligned to Saskatchewan Medical Association, while maintaining a reporting relationship with Saskatchewan Association of Health Organizations and Saskatchewan Health. The position continuation should take into account the recommendations and input from the recent evaluation, and include inputs derived from suitable consultation and reconsideration of role and scope of the position.

Recommendation:

We recommend that the updated list of medical students and their contact points be made available to the Recruitment Coordinator, as soon as is reasonably possible at the commencement of each academic year, with the understanding that the Recruitment Coordinator accepts responsibility for maintaining the privacy of the medical student contacts, though with the further understanding that the Recruitment Coordinator will use this information in dealing with Health Districts' intention to recruit trainees.

Recommendation:

We recommend that there continue to be, on at least an annual basis, a well-publicized and promoted Recruitment Fair involving undergraduate medical education, postgraduate medical education trainees and Health Districts.

Recommendation:

Building on the success of rural rotations between second- and third-year, we recommend that trainees between first- and second-year of medical school training be offered opportunities for rural rotations, with joint assignments to clinicians and administrative staff, so as to develop a broader understanding of the linkage between clinical and management services, while being exposed to the realities and values of rural practice.

Recommendation:

We recommend that the Junior Rotating Student Interns continue to undertake clinical rotations in Regina, as a means of gaining additional clinical experience in the final-year curriculum.

Recommendation:

It is recommended that the faculty agreements of full-time tenured, full-time without-term, and part-time faculty be revised, with the objective of ensuring that they include the appropriate provisions and proportions for the academic, clinical and research services to be provided, the related compensation, and other terms and conditions as appropriate.

Recommendation:

We recommend that the College of Medicine establish a Graduate Training Committee responsible to the College of Medicine and Faculty of Graduate Studies, to set policies and standards for the development of graduate studies within the College of Medicine. This would include, but not be limited to, review and approval of admissions to graduate studies and review of research proposals and programs for dissertation. The Graduate Training Office for the College of Medicine should be established in alignment with the office of the Associate Dean Research.

Recommendation:

The Associate Dean Research should commence an internal grant review process to strengthen grant submissions and increase the success rate for competitive research funding.

Recommendation:

Continuing Medical Education should be reassessed from the perspective of the impact of financial organization and cost recovery on program and content delivery. In addition, continuing medical education should be aligned and report to the Associate Dean Education. Further, we suggest that Saskatchewan Medical Association reconsider its level of financial support, as a strategic investment in the interests of its physician members. Accordingly, Saskatchewan Medical Association should have a meaningful involvement in the design, direction and content of continuing medical education programs. Further, we recommend that continuing medical education programs broaden their scope to include expertise in management education for physicians, as a means of supplementing clinical education programs designed to strengthen practice.

Recommendation:

We recommend that the College of Medicine, in consultation with the College of Physicians and Surgeons of Saskatchewan, establish physician upgrade and remediation programs which should be linked to the office of Continuing Medical Education and report to the Associate Dean Education. We believe that the Department of Family Medicine should take the lead and be resourced to develop a program of physician assessment and competency review, together with remediation programs and support, knowledge and skills upgrade, assessment for practice re-entry and programs of reintegration. In addition, we believe that the College of Medicine is particularly well suited to assist other Health Districts in peer review and quality improvement processes for physicians. In order to accomplish this recommendation, we urge the College of Medicine to better understand the needs of Health Districts and their physicians and to develop a thoughtful and collaborative approach to engaging and carrying out these opportunities.

Recommendation:

We recommend that the College of Medicine, University of Saskatchewan, Saskatoon Health District, and Department of Post-secondary Education commence a task force to look at knowledge resources, including but not limited to, the University of Saskatchewan's Health Sciences library, but also other creative opportunities to act as a provincial knowledge resource, with meaningful ties to Saskatchewan Health and to Saskatchewan Health Information Network.